MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the deaths of Ruby Ann Brewer and Shanzel Lee Brewer

Find in respect of Ruby, pursuant to Section 28(1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is Ruby Ann Brewer;
b) Ruby died in the circumstances set out further in this finding;
c) The cause of Ruby's death was asphyxia due to smoke inhalation; and
d) Ruby died on 11 June 2017 at 69 Austins Road, Turners Marsh, Tasmania.

Find in respect of Shanzel, pursuant to Section 28(1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is Shanzel Lee Brewer;
b) Shanzel died in the circumstances set out further in this finding;
c) The cause of Shanzel's death was asphyxia due to smoke inhalation; and
d) Shanzel died on 11 June 2017 at 69 Austins Road, Turners Marsh, Tasmania.

Introduction

1. Sisters, Ruby and Shanzel Brewer, 13 years and 11 years old respectively, died when the shed in which they were sleeping caught fire and burnt to the ground during the night of 10-11 June 2017.

2. In making the findings above, and those that follow, I have had regard to the evidence gained in the comprehensive investigation into Ruby and Shanzel's deaths. The evidence includes:

- Tasmania Police Report of Death for the Coroner – Ruby;
- Tasmania Police Report of Death for the Coroner – Shanzel;
- Regulation 23 affidavit (life extinct) – Ruby;
- Regulation 23 affidavit (life extinct) – Shanzel;
- Affidavit of Constable Haywood – identification – Ruby;
- Affidavit of Constable Haywood – identification – Shanzel;

- Affidavit of Colin O'Connor – identification – Ruby;
- Affidavit of Colin O'Connor – identification – Shanzel;
- DNA Identification Report, Carl Grosser, Forensic Scientist;
- Forensic Science Service Tasmania report – Ruby;
- Forensic Science Service Tasmania Report – Shanzel;
- Rule 19 Affidavit and report – Dr Donald Ritchey, Forensic Pathologist – Ruby;
- Rule 19 Affidavit and report – Dr Donald Ritchey, Forensic Pathologist – Shanzel;
- Record of Interview – Clifford James Brewer – 11 June 2017;
- Record of Interview – Clifford James Brewer – 18 August 2017;
- Affidavit of Jemma Louise Janice Stebbings-Cowen;
- Affidavit of John David Egan;
- Record of Interview – Zachary Jeffrey Greaves;
- Affidavit of Tina Maree Millar;
- Record of Interview – Kristy Katherine Seymour;
- Record of Interview – Shaun James Holden;
- Affidavit of Patricia Anne Greaves;
- Record of Interview – Tom Lambert Lefevre;
- Record of Interview – Craig Colin Lohrey;
- Statutory Declaration of Detective Senior Constable Russell Forsyth;
- Affidavit of Detective Senior Constable Gavin Chugg;
- Affidavit of Sergeant Phillip Norton;
- Affidavit of Constable Veronique Smith;
- Affidavit of Constable Steven Gillingham;
- Affidavit of Constable Shaun Gleeson;
- Affidavit of Constable Madeleine Haywood;
- Affidavit of Senior Constable Timothy Champion;
- Affidavit of Sergeant Gregory Rogers;
- Affidavit and photographs – First Class Constable Brett Tyson;
- Affidavit and photographs – Senior Constable Peter McCarron;
- Affidavit of Sergeant Ivan Radosavljevic;
- Affidavit of Police Officer (rank unknown) Daniel Hortle;
- Affidavit of Constable Aaron Hart;
- Recording of '000' call;
- Tasmanian Fire Service Fire Investigation Report;
- Incident Log – Tasmania Fire Service;
- Supplementary Fire Report;

- TechSafe Australia – Fire Investigation Report;
- Documents – Lane Electrical Services;
- Report – Intertek;
- Planning files – Launceston City Council;
- Child Protection file relating to Ms Kristy Seymour;
- Department of Community Corrections Serious Event Review Team Report- 30 July 2019;
- Electricity Records – 69 Austins Road, Turners Marsh;
- Certificate – section 86(1) of the *Occupational Licensing Act* 2005 – Bryan Stephen Pike;
- Peer review report – Detective Sergeant Chris De Bruin, Arson Squad, Western Australia Police Force; and
- Affidavit of Clifford James Brewer, sworn 27 October 2020.

What a Coroner Does

3. In Tasmania, a coroner has jurisdiction to investigate any 'reportable death'.[1] A 'reportable death' includes a death where the death occurred in Tasmania and it was unexpected or to have resulted directly or indirectly from an accident.[2] Ruby and Shanzel's deaths meet this definition.

4. When investigating any death, a coroner's role is to thoroughly investigate the death and answer the questions (if possible) that section 28 of the *Coroners Act* 1995 asks. Those questions include who the deceased was, how he or she died, what was the cause of the person's death and where and when it occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[3] A coroner is required to make findings of fact from which others may draw conclusions.[4]

5. A coroner does not have the power to charge anyone with crimes or offences arising out of the death the subject of investigation. In fact, a coroner may not even say in a finding that she or he thinks that someone has committed a crime in relation to the death (or deaths) being investigated.[5]

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[1] See section 21 of the *Coroners Act* 1995.
[2] See section 3.
[3] *R v Tennent; Ex parte Jager* [2000] TASSC 64 at part 7.
[4] *Keown v Khan* [1999] 1 VR 69 at 75 -76.
[5] See section 28 (4).

6. As noted above, one matter that the *Coroners Act* 1995 requires is that a finding be made about how death occurred. This involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

7. A coroner may comment on any matter connected with the death into which he or she is enquiring. The power to make comment 'arises as a consequence of the [coroner's] obligation to make findings … It is not free-ranging. It must be comment "on any matter connected with the death" … It arises as a consequence of the exercise of the coroner's prime function, that is, to make "findings".'[6]

8. The standard of proof applicable to a coronial investigation is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an investigation reaches a stage where findings may reflect adversely on someone, the law is that the standard applicable is that set out in the well-known High Court case of *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved must be approached with great caution.[7]

The Property and Living Arrangements

9. Ruby and Shanzel, the biological daughters of Clifford Brewer were, at the time of their deaths, living with Mr Brewer and his partner, Kelly Barnes, along with Jemma Stebbings-Cowen and three other children – Kasey, Kane and Peyton. Shanzel and Ruby were full sisters, the children of a previous relationship between Mr Brewer and Ms Patricia Greaves.

10. At the time of the deaths of the girls, the family unit (two adults, an 18-year-old friend of the family, and five children) were all living on a rural block, some 3.1 hectares in size, located at 69 Austins Road, Turners Marsh. It appears that most of the property was covered by scrub, but had a number of buildings used for residential and associated purposes in a clear area, accessed from the main road by a dirt road.

11. Mr Brewer and the girls moved into the property around December 2015. It was owned by Kristy Seymour. Ms Seymour allowed the family to live there, although no formal lease agreement seems to have been in place. Originally, Ms Seymour owned the

[6] *Harmsworth v State Coroner* [1989] VR 989 at 996.
[7] (1938) 60 CLR 336.

property jointly with a former partner. In 2008, the property was transferred into her name only.

12. The evidence is that around 2009, Ms Seymour and her then partner, Shaun Holden, began to build a 6 metre x 6 metre galvanised shed approximately 20 metres west of the house on the block (which had been transported from another location and situated on the block in about August 2005). It is in this shed – described as a (or 'the') granny flat - that the girls died.

13. At the time they commenced building the shed, Ms Seymour and Mr Holden did not have either a planning or building permit. Complaints were made to the local planning authority (the Launceston City Council) concerning the construction of the shed and the fact that children were apparently living in it. The matter was investigated by the Council and the outcome was that an application for a building permit was made by Ms Seymour to the Launceston City Council in around October 2009. At about this time, Ms Seymour was operating the property as some type of foster home, caring for various children placed with her by Child and Family Services (CFS). It is evident from material obtained as part of the investigation into the death of the girls that CFS were aware that children placed under the care of Ms Seymour at 69 Austins Road, Turners Marsh, would be living in a shed. Further, that organisation actively encouraged the construction of the shed and provided financial assistance to Ms Seymour, assisting with the building cost. There is no evidence of any communication between CFS and the Council in relation to whether any approvals existed for the shed to be used to house children in care.

14. The shed had a concrete floor, over which was laid a 'floating' timber floor. It was lined with pine panelling and separated into two bedrooms and a lounge type area. It had no water or plumbing and only one entrance. Both bedrooms had carpet on the floor.

Electrical Connections

15. There is clear evidence that during Ms Seymour's time on the property, and when the Brewer family unit was living there, the shed was connected to mains electricity from the main dwelling.

16. The evidence satisfies me that that electrical connection was made by Bryan Stephen Pike. Enquiries carried out as part of the investigation into Ruby and Shanzel's deaths indicate that between 2008 and 2012, Mr Pike was the holder of a 'restricted electrical license', which authorised him to perform restricted electrical work upon refrigeration and air conditioning units. It is apparent that at no relevant time did he hold the

necessary licence to perform electrical work of the type carried out by him at the property. I note that in 2013 he was investigated by the regulator for performing unlicensed electrical work and was cautioned after that investigation. Investigators attempted to speak to Mr Pike in relation to the coronial investigation into the girls' death. He refused to cooperate.

17. Ruby and Shanzel were, in June 2017, sleeping in the shed. They had been for around 12 months. Ruby slept in the front bedroom of the shed and Shanzel in the rear.[8] The rest of the people living at the property were sleeping in the main house.

Circumstances of Death

18. Both girls ate their evening meal in the main residence on Saturday, 10 June 2017. After eating, Shanzel returned to the shed to watch television in her room. Ruby stayed in the main residence watching a movie with her father, Ms Barnes and Ms Stebbings-Cowen. She went to the shed around 11.00pm to go to bed. Neither girl was seen alive again.

Response of Emergency Services

19. Mr John Egan from 65 Austins Road called '000' at 2.37am on 11 June 2017 to report a fire. Not unreasonably, he thought that the bush was alight and told the operator that. There was some delay (a matter of four or five minutes) in paging local brigades, due to some difficulty identifying the address of the fire. The information was re-paged to the closest volunteer fire brigades (Lilydale and Karoola) several times, but neither brigade responded. Individual brigade members appear to have been contacted by the Firecomm operators, but without any success.

20. At 3.01am the status of the call was upgraded by Firecomm to a structural fire with people possibly entrapped. This information was also re-paged. Still, no brigade responded. Finally, at 3.06am and 3.07am respectively, crews from the Rocherlea and Lilydale Brigades responded, arriving at 3.20am and 3.26am respectively, nearly an hour after the initial '000' call from Mr Egan. By then, the shed had burnt to the ground and both girls were dead. Even allowing for the isolated area of the property, the response by Tasmania Fire Service crews was, in my view, poor. However, the evidence does not allow me to conclude that any earlier arrival would have altered the outcome.

[8] Record of Interview with Clifford James Brewer, 11 June 2017, page 6.

Investigation – Identification and Forensic Pathology

21. The fire was brought under control, extinguished and the scene examined. At 4.09am, the girls' bodies were found in the charred ruins of the shed. The body, later identified as Shanzel's, was found in the rear bedroom, on the remains of a double bed. The body, subsequently identified as Ruby's, was found face down on the floor of the front bedroom, just to the side of her single bed, with her legs under the remains of the bed and her head facing towards the shed's front door. Both bodies were photographed and then removed and taken by mortuary ambulance to the Royal Hobart Hospital. [9]

22. Because both bodies were so badly burnt, identification by a combination of DNA analysis and forensic dental examination was required. The reports associated with those procedures satisfy me that the bodies found in the remains of the shed were those of Ruby and Shanzel.

23. Autopsies were carried out on both bodies by experienced Forensic Pathologist, Dr Donald Ritchey MD, MSc, FRCPA. Dr Ritchey expressed the opinion, which I accept, that both girls died as the result of asphyxia due to smoke inhalation. This conclusion is supported by the results of toxicological analysis of samples taken at autopsy. That analysis, carried out at the laboratory of Forensic Science Service Tasmania, showed that Ruby had a carboxyhaemoglobin level of 80% saturation and Shanzel 52%. Both these levels are within the reported fatal range.

Fire Investigation

24. The investigation into the cause of the fire commenced at the scene. An investigator from the Tasmania Fire Service, Station Officer (SO) Anthony Goss, attended the scene and conducted a detailed examination of what was left of the structure. SO Goss noted that 'considering that combustion [had] occurred for more than an hour without suppression within the [structure], significant to complete consumption of the majority of fire language indicators [had] occurred making it difficult to ascertain an exact area of fire origin.' He identified that the roof of the structure sank significantly towards its middle, indicating an area of fire origin in the centre of the structure. SO Goss found an area with an indication of electrical arcing in the rear bedroom, suggesting that it was likely that electrical arcing had occurred at that point, which ignited combustible materials in the form of a timber base plate and wall lining at floor level.

[9] See affidavit of Constable Peter Lyndon McCarron (and attached photographs), sworn 5 July 2017.

25. SO Goss expressed the opinion that there were no noggins in between the studs, which would allow superheated material from any electrical arcing to transfer down the wall cavity. SO Goss was unable to identify precisely the area of fire origin, however, considering all of the evidence, thought that it was likely that there had been an electrical fault within the structure most likely due to electrical arcing rather than the failure of any particular electrical appliance. He identified several possible ignition sources for the fire. The possible sources included:

    a. An electric fan heater connected to an extension cord running from the main residence;
    b. A television, power point and (probable) remains of a play station;
    c. Another television, power point and phone charger;
    d. A small fluorescent light box; or
    e. Energised power cords.

26. SO Goss found no evidence to suggest that some type of ignition source had been introduced externally. He found no evidence of the involvement of any type of accelerant.

27. In summary, SO Goss' opinion was that the fire had commenced in the rear bedroom (occupied by Shanzel) and moved towards the front bedroom (occupied by Ruby). The position of the girls' bodies in the respective bedrooms tends to support this opinion. The location of Shanzel's body in the rear bedroom (on the remains of her bed) suggests that she did not attempt to leave the room. On the other hand, the position of Ruby's body in the front bedroom (away from her bed, near the shed's external door) suggests she may have been attempting to exit the structure when she collapsed.

28. SO Goss found no evidence to suggest that the cause of the fire was deliberate. He concluded that either the cause of the fire was from an electrical fault causing combustible materials within the structure to ignite, or, from the introduction of a mobile ignition source (such as a candle) which ignited combustible materials.

29. Finally, SO Goss found no evidence that a smoke detector or detectors had been installed in the shed. I am satisfied that, in fact, there were no smoke detectors fitted in the shed. I note Mr Brewer's contention that the fitting of smoke detectors where his daughters slept was the responsibility of the property owner, Ms Seymour[10]. I accept this was so. The *Residential Tenancy (Smoke Alarms) Regulations* 2012 make this clear. I

[10] Affidavit of Clifford James Brewer, sworn 27 October 2020, paragraph 32.

note the same regulations cast an obligation on a tenant to ensure batteries are replaced, smoke alarms are tested and a property owner notified in the event of a smoke alarm failure.[11]

30. TechSafe, Australia, on behalf of the Electrical Regulator, also carried out an inspection of the premises. The inspector, Mr Richard Tattersall, was unable to find sufficient evidence to reach a concluded view as to the most probable cause of the fire. Mr Tattersall found a number of defects during his investigation,[12] including:

    a. Unsheathed cables and exposed live terminals of white plug-in cord connection under the main house;
    b. A socket outlet in the kitchen requiring reattachment to wall plate;
    c. The underground conduits on the exterior wall of the shed requiring mechanical protection; and
    d. Exposed live parts on another socket outlet in the other shed.

31. However, he found no evidence that any of these defects caused or contributed to the fire. They are, to my mind, indicative of the dangerous standard of the electrical work at the property.

32. All of the conclusions in all of the reports were reviewed, at my request, by Detective Sergeant Chris De Bruin, head of the Western Australia Police Arson Squad. Detective Sergeant De Bruin is a highly experienced fire investigator and a leading national expert in the field. He said that he found no fault with the investigation, or any of the conclusions reached.

33. I am satisfied that the investigations by SO Goss and Mr Tattersall were professional and as comprehensive as the circumstances allowed. I accept that both are qualified to express the opinions that they did, that their methodology was appropriate, and their conclusions reliable. I accept their opinions. It is evident that the most likely source of the fire, which incinerated Ruby and Shanzel, was electrical.

Electrical Supply

34. Given that the electricity supply to the shed was the likely cause of the fire, the coronial investigation focused upon that issue. It is clear, on the evidence, that Mr Brewer and his family had ongoing problems with the electrical supply at the property. Mr Brewer told

[11] *Residential Tenancy (Smoke Alarms) Regulations* 2012, Division 3.
[12] TechSafe Report, page 6.

police that the problems started about six months after they moved in.[13] The problems involved circuit breakers 'tripping'. Mr Clifford said he contacted the property owner, Ms Seymour. She sent first, her son, and second, her boyfriend, to look at the problem. There is no evidence either man was an electrician.

35. Eventually, on 12 May 2017, Mr Tom Lefevre, a qualified electrician employed by Lane Electrical Services, went to the property at Ms Seymour's request. Mr Lefevre found a live electrical cable 'just hanging underneath' the main home, which he made safe.[14] Mr Lefevre said that Mr Brewer also complained that whenever he used his welder in the other part of the shed (adjacent where the girls slept), the circuit breakers 'tripped'. Mr Lefevre offered to look further at the problem, and in particular, at the shed. Mr Brewer declined his offer[15]. I note in his affidavit of 27 October 2020, Mr Brewer did not deny Mr Lefevre's account, instead saying that "it was not [his] prerogative to accept or decline any such offer ***if it was made***" [emphasis added].[16]

36. Mr Lefevre later told investigators that he considered the electrical circuit at the property to have been overloaded.

37. It emerged during the investigation that Mr Brewer had performed electrical work at the property.[17] Mr Brewer was not qualified to carry out that work. He was not trained to do that work, although he told police that he "done a course years and years ago...family courses and stuff".[18]

38. The other source of power to the shed was by two standard extension cords, joined together, which ran from the lounge room of the main house, out a window and over the drive way to the shed. The extension cord entered the shed through a slot that had been cut in an aluminium window. It was plugged into an upright fan heater. The significance of this is that the joining of extension cords together can reduce the effectiveness of any circuit breakers, however, given the lack of conclusive evidence as to the source of the fire which killed the girls, I am unable to say, with any degree of certainty, that either Mr Brewer's unauthorised electrical work or the extension cords or both were the cause of the fatal fire. In reaching this conclusion, I am especially mindful of the need for me to apply the so-called *Briginshaw* standard.[19]

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[13] Record of Interview Clifford James Brewer 18 August 2017, page 2 - 3.
[14] Record of interview, Tom Lambert Lefevre, 21 June 2017, page 2.
[15] *Supra,* pages 7 and 12.
[16] Affidavit of Clifford James Brewer, sworn 27 October 2020, paragraph 34.
[17] Record of interview, Clifford James Brewer, 18 August 2017, pages 13-19; Affidavit of Clifford James Brewer, sworn 27 October 2020, par 15(e).
[18] *Supra* page 19.
[19] *Briginshaw v Briginshaw, supra*.

39. Applying the same principle, I cannot be sufficiently satisfied that the original electrical work, carried out by un-licenced electrician, caused or contributed to the happening of the fire.

Submissions

40. Consistent with the requirement to afford any party likely to be the subject of an adverse finding the opportunity to be heard before any such finding is made, these findings, in draft, were sent to Ms Seymour, Mr Pike, Mr Brewer and the Tasmania Fire Service.

41. Mr Brewer requested access to the complete file to enable his response to be made. That was facilitated over the course of several weeks. I subsequently received a lengthy response from Mr Brewer. His response, amongst other things, took issue with aspects of the investigating officer's subject report (even though he acknowledged he was aware the subject report itself was not evidence), suggested I make recommendations about how police should conduct interviews, and made a series of complaints about matters that occurred after his daughters' tragic deaths.

42. To the extent that it is relevant, I should say that I am quite satisfied that the investigation by police was thorough, professional and conducted with compassion. I reject any suggestion that Mr Brewer was in any way treated unfairly.

43. Otherwise, I have given his response appropriate weight.

44. The Tasmania Fire Service's reply, in full (omitting the formal parts) was:

> *"Whilst it is not of material concern in the Coroner's findings, we do see an opportunity to improve TFS initial response protocols and will review them accordingly".*

45. The response is afforded appropriate weight.

46. Mr Pike made a brief response, to which I have also had regard.

47. Ms Seymour did not reply. I therefore assume that she does not take issue with any of the conclusions I have reached in this finding.

48. I do note that because the actual source of the electrical fire was unable to be determined, I have made no finding identifying any person as being responsible for the deaths of Ruby and Shanzel.

Comments and Recommendations

49. The deaths of Ruby and Shanzel were an indescribable, but avoidable tragedy. Their deaths may well have been avoided if cheap and easily available smoke detectors had been installed in the shed in which they were sleeping. Coroners, fire authorities and safety experts have repeatedly warned about the need for properly operating smoke detectors to be installed in homes. I **recommend** that every home occupier install and maintain properly operating smoke detectors, especially in rooms where people are sleeping.

50. Further, it is quite clear that the electrical work at the property was dangerous. The ultimate responsibility for this rests with Ms Seymour. It is also quite clear that Mr Brewer had attempted to do electrical work himself and declined the assistance of a qualified electrician. I **comment** that no one should ever carry out electrical work of any kind unless they are properly qualified and licenced to do so.

51. I wish to express my particular thanks to Detective Senior Constable Russell Forsyth, Tasmania Police, for his thorough investigation and report. In addition, I am particularly grateful to Detective Sergeant Chris De Bruin, Western Australia Police Force, for his assistance.

52. I convey my sincere condolences to the family and loved ones of Ruby and Shanzel.

Dated: 14 December 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner