IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 2905

FINDING INTO DEATH WITH INQUEST

*Form 37 Rule 60(1) Section 67 of the **Coroners Act 2008***

Inquest into the Death of: CHERYL MAY CURRIE

Hearing Dates:	12, 13, 14, 15 and 18 March 2013 and 20 June 2013 (six days)
Appearances:	• Metropolitan Fire Brigade represented by Christopher Wiseman, General Counsel, Metropolitan Fire Brigade. • Department of Human Services represented by Ms Erin Gardner of Counsel, instructed by in-house lawyers. • The Transport Accident Commission represented by Ms Áine Magee of Counsel, instructed by in-house lawyers. • Independence Australia represented by Olivia Trumble of Counsel, instructed by Moores Legal. • Royal District Nursing Services, represented by Megan O'Brien, consultant lawyer for the Royal District Nursing Services.
Counsel Assisting the Coroner	Karen Argiropoulos of Counsel, instructed by Jodie Burns, Senior Legal Counsel, Coroners Court of Victoria.
Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	28 August 2015
Delivered At:	65 Kavanagh Street, Southbank 3006

I, AUDREY JAMIESON, Coroner having investigated the death of CHERYL MAY CURRIE
AND having held an Inquest in relation to this death on 12, 13, 14, 15 and 18 March 2013 and 20 June 2013 at Melbourne
find that the identity of the deceased was CHERYL MAY CURRIE
born on 8 September 1969
and the death occurred on 12 June 2009
at 3 Lonsdale Avenue, Hampton East 3188
from:

1a) SMOKE INHALATION
2 PARAPLEGIA

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. In the early hours on 12 June 2009, Cheryl May Currie (**Ms Currie**), a complete paraplegic, died, aged 39 years old, of smoke inhalation from a fire in her home at 3 Lonsdale Avenue, Hampton East (**Home**). At the time of her death, she was alone in her home and confined to bed.

BACKGROUND CIRCUMSTANCES

2. Ms Currie's complete paraplegia resulted from an incident that occurred on 1 September 1998, when she attempted suicide by jumping in front of a train. Following this incident, the Transport Accident Commission (**the TAC**) accepted her claim for compensation.
3. In June 2002, Ms Currie commenced residing at her Home, owned by the Department of Human Services (**the DHS**),[1] Office of Housing.
4. The DHS purpose built the Home in consultation with Ms Currie, her occupational therapist, the TAC case manager and an architect, in order to meet her specific mobility and familial needs.
5. Initially, Ms Currie lived at the Home with her then partner, Greg Hagan, and her two children, Sharlene and Joshua. Also living at the Home were Sharlene's children.

[1] In 2009 it was known as the Department of Human Services. At the time of finalising the Finding the Department had changed its name to the Department of Health and Human Services.

6. In 2006, Mr Hagen moved out of the Home and in December 2008, Sharlene and her children moved out. Up until Ms Currie's death, Joshua spent some nights at the Home and some nights away from it.
7. Ms Currie had a history of schizophrenia for which she was prescribed medication and had been admitted into hospital on a number of occasions.
8. At the time of her death, Ms Currie had multiple medical concerns relating to her paraplegia, including:
    a. colostomy in situ;
    b. recurrent pressure ulcers;
    c. infections relating to an indwelling urinary catheter; and
    d. osteomyelitis (bone infection).
9. Ms Currie was being provided with support and care in her home by the following providers, funded by the TAC:
    a. Independence Australia (formerly known as Para-Quad)[2] provided personal care attendants at Ms Currie's home for two shifts each day (generally from 9.00am-12.00pm and 6.00pm-9.00pm). The personal care attendants provided personal care, meal preparation and domestic assistance.[3] The TAC funded Ms Currie to receive attendant care services from April 2001 until the time of her death on 12 June 2009. Over the course of that time, the amount of hours funded by the TAC varied. At the time of her death, Ms Currie was funded to receive 196 hours of care per 28 days (seven hours per day) for personal care and domestic assistance;
    b. Nurses from the Royal District Nursing Services (**RDNS**) visited Ms Currie in her home three days per week (usually Monday, Wednesday and Friday) to attend to wound care for pressure ulcers related to Ms Currie's paraplegia;
    c. Dr Guiseppe Joseph Toscano (**Dr Toscano**), Ms Currie's general practitioner since 7 June 2002, visited her at home as needed;

[2] Independence Australia (formally ParaQuad) is a not for profit organisation providing attendant care services to people with a disability. In April 2013 Independence Australia had 473 carers under employment, and; 723 clients serviced by the organisation.
[3] Independence Australia entered into Service Agreements with the TAC for the provision of services to individuals who received funding for in-home care services. On the 27 March 2001, ParaQuad was engaged by the TAC to provide in-home attendant care services to Ms Currie.

d. Jenny Sparks, occupational therapist, provided care when requested by the TAC. Ms Sparks had not provided any occupational therapy services to Ms Currie since August 2008; and

e. A VitaCall Personal Emergency Response Unit (**PRU**) was installed in Ms Currie's home in November 2008. The PRU and pendant worn around Ms Currie's neck enabled her to call for medical emergency assistance 24 hours a day.

10. Ms Currie's prescribed medications were prepared in blister packs from which she self-administered her medications. However, she regularly needed reminding to take her medications by her carers and family members.

11. Ms Currie also received psychiatric assistance and care from Southern Mental Health who allocated Ms Anne Ball as her case manager. The TAC did not fund this assistance as Ms Currie's psychiatric conditions predated her claim.

12. Between 10 January 2009 and 20 March 2009, Ms Currie was hospitalised at the Monash Medical Centre Psychiatric Unit following an attempt of self-harm.

13. On 19 May 2009, Ms Currie underwent surgery at the Dandenong Hospital to repair pressure sores on her left ischial area (upper thigh). Following this procedure, she was discharged on 22 May 2009 to her home, where she was confined to bed until the wound healed, which was expected to heal by July 2009.

THE CIRCUMSTANCES IN WHICH THE DEATH AND FIRE OCCURRED

9-11 June 2009

14. On 9 June 2009, Judith Axford (**Ms Axford**), Independence Australia, senior personal attendant carer, attended to Ms Currie in her Home for a total of 8 hours and 15 minutes, from 9.15am to 5.30pm.

15. On 10 June 2009, Ms Axford again attended for a total of 6 hours and 15 minutes, from 8.30am to 2.45pm. An agency worker from Care and Compassion also attended for a total of three hours from 5.00pm to 8.00pm. At 7.00pm, Dr Toscano attended Ms Currie's Home, at the request of Ms Axford because she was concerned about Ms Currie's increasingly agitated state. Dr Toscano reviewed the blister pack of medication with Ms Currie and made sure she had taken her evening

medications. Dr Toscano states, "*She was paranoid but not suicidal or homicidal. I organised with her to review her the following evening*".[4]

16. On 11 June 2009, the same agency worker from Care and Compassion attended for a total of three hours from 5.00pm to 8.00pm. While Independence Australia were able to identify a roster that indicated an agency staff member attended for the 9.00am to 1.00pm shift on this day, corroborating documentation such as a timesheet could not be produced, and it is accordingly possible that the agency worker did not attend for that shift. Again, on this day, at approximately 7.00pm, Dr Toscano visited Ms Currie, and found "*she was more stable, she had no visual or auditory hallucinations, but was still paranoid and once again I reviewed her medication with her and made sure she had her evening medications. ·I reviewed her skin problems and we had a discussion about her future when Cheryl said she was keen to get out of bed so she could start a flower arrangement-course.*"[5]

12 June 2009

17. On 12 June 2009, Ms Currie accessed her VitaCall PRU alarm at 2.29am[6] alleging that neighbours were trying to kill her. In response, the VitaCall operator made unsuccessful attempts, at 2.40 am, to contact Joshua and Sharlene Currie.[7]
18. Later that morning, at 5.30am, a neighbour of Ms Currie was woken by the sounds of glass smashing and screaming. The neighbour looked outside, observed flames coming out of Ms Currie's bedroom window, and called 000.
19. The Metropolitan Fire Brigade's fire fighters attended Ms Currie's Home at 5.38am, at which time flames were emanating from the roof.
20. Mr Neil Jenkins, Metropolitan Fire Brigade (**MFB**) fire fighter, located Ms Currie directly behind the timber front door after he attempted to push it open about 8 inches, but found her body was blocking the doorway.[8] Fire fighters assisted Mr Jenkins to pick Ms Currie up and take her outside where cardiopulmonary resuscitation (**CPR**) was commenced.

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[4] Inquest brief, page 14.
[5] Inquest brief, page 15.
[6] Records produced by VitaCall show that in the days prior to her death, Ms Currie used the PRU to contact VitaCall in relation to various matters, and on some occasions, the police attended at her home in response to her concerns. The PRU is primarily to be used for medical emergencies.
[7] Transcript, page 264.
[8] Inquest brief, page 42.

21. Ambulance Victoria paramedics arrived at the scene at approximately 5.50am, whereby they assessed Ms Currie and found that she was not breathing, did not have a pulse, had fixed and dilated pupils and recorded an asystolic rhythm on the cardiac monitor. CPR ceased at 5.59am.
22. Ms Currie's wheelchair was located by fire fighters in the ensuite bathroom, approximately four metres from the side of her bed. Despite not having access to her wheelchair, Ms Currie managed to get herself out of her bed and to the front door of her Home, a distance of some eight metres.[9]
23. Fire safety documentation discovered at Ms Curries' premises after the fire included literature produced by the disability service division of the DHS (and prepared with the assistance of the MFB) to assist carers who support people on individual disability support packages.

JURISDICTION

24. At the time of Ms Currie's death the *Coroners Act 1985* (Vic) applied. From 1 November 2009, the *Coroners Act 2008* (**the Act**) has applied to the finalisation of investigations into deaths that occurred prior to the commencement of the Act.[10]
25. Ms Currie's death was unexpected and therefore a reportable death under the *Coroners Act 1985* (Vic).

PURPOSE OF A CORONIAL INVESTIGATION

26. The Coroners Court of Victoria is an inquisitorial jurisdiction.[11] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[12] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[13]
27. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations

[9] Transcript, page 169.
[10] Coroners Act, section 119 and Schedule 1.
[11] Section 89(4) *Coroners Act 2008*.
[12] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.
[13] This is the effect of the authorities- see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

by coroners, generally referred to as the 'prevention' role.[14] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[15] These are effectively the vehicles by which the prevention role may be advanced.[16]

28. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.
29. Detective Senior Constable Luke Walsh was the nominated coroner's investigator[17] and prepared the Inquest brief.
30. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.
31. Ms Currie was not a person placed in 'custody or care' as defined by section 3 of the Act. Ms Currie was a public housing tenant only, her Home being owned by the DHS, Office of Housing. It was therefore not mandatory to conduct an Inquest into the circumstances of her death, however, I exercised my discretion pursuant to section 52(1) of the Act to hold an Inquest because I had identified matters of public health and safety that required further investigation.
32. This finding draws on the totality of the material, the product of the coronial investigation of Ms Currie's death. That is, the court records maintained during the coronial investigation, the Inquest brief and the evidence obtained at the Inquest.
33. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

[14] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act of the Coroners Act 1985 where this role was generally accepted as "implicit"
[15] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
[16] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[17] A coroner's investigator is a member of the police force nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions directly from a coroner and carries out the role subject to the direction of a coroner.

STANDARD OF PROOF

34. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[18] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:
    - the nature and consequence of the facts to be proved;
    - the seriousness of an allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.
35. The effect of the authorities is that coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

INVESTIGATIONS

Identity of the deceased

36. The deceased's identity was not in dispute and required no further investigation.[19] Therefore, I formally find that the deceased was Cheryl May Currie, born 8 September 1969.

Medical Cause of Death

37. On 18 June 2009, Dr Melissa Baker (**Dr Baker**), Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Ms Currie, which identified extensive soot deposition within the airways. Dr Baker concluded that the cause of death was smoke inhalation with paraplegia contributing to her death, but not directly causing it.

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[18] (1938) 60 CLR 336.
[19] See 'Coroners Release Authority and Confirmation of Name' signed by Sharlene Currie dated 18 June 2009.

38. Dr Baker noted charring and blistering of the skin of Ms Currie's lower legs, soot deposition over her face and hands and commented that Ms Currie's impaired mobility might have affected her ability to escape from the fire.
39. Dr Baker also noted that Ms Currie was wearing a chain around her neck with an alarm device attached to it.
40. Toxicological analysis of the blood sample taken from Ms Currie after death revealed elevated carboxyhaemogloblin (63% saturation) and hydrogen cyanide (2.6mg/L), both of which are toxic fumes produced during fires. Carboxyhaemoglobin levels greater than 50% are generally considered to be fatal, and levels of hydrogen cyanide in excess of 1mg/L are considered to be life threatening.
41. Toxicological analysis also revealed the presence of olanzapine and quetiapine (medications used in the treatment of schizophrenia) at concentrations consistent with therapeutic use. Diazepam, a sedative/hypnotic drug of the benzodiazepines class, and its active metabolite nordiazapam were also detected at low levels.

The fire investigation

42. The fire scene was jointly investigated by John Kelleher (**Mr Kelleher**), scientist at the Victoria Police Forensic Science Centre and Station Officer Rodney East (**SO East**) of the MFB Fire Investigation and Analysis Unit. I consider both Mr Kelleher and SO East to be experts with respect to fire investigations.
43. SO East tested one of the smoke detectors and found it to be working correctly, while the other smoke detector was damaged to an extent that testing was not possible.
44. SO East's expert evidence as to the most probable cause of the fire was *"the imprudent use of smoking materials whilst the occupant was incapacitated in bed."*[20] Both Mr Kelleher and SO East concluded that the point of the fire's origin started on or was adjacent to the bedside table on the south (right) side of the bed. The burn patterns indicated a higher-level fire,[21] initially starting as a smouldering fire before breaking into flames and combustion.[22]

[20] Report of SO East included in Exhibit (X)9.
[21] Report of SO East included in X9 -refer to Note 4.
[22] Transcript, pages 107- 108, 126 and 193.

45. Mr Kelleher noted that Ms Currie had severe burning to her feet and legs, probably from direct exposure to the fire, which indicated that she had been lying or sitting close to the fire at some stage.
46. SO East raised concerns regarding the inadequacy of systems in place for the testing of the smoke detectors to ensure that they were operating correctly.
47. Mr Kelleher and SO East also noted several cigarette burn marks on furniture in the lounge room at Ms Currie's Home, which suggested that a person(s), on occasion(s), had been careless with cigarettes.

Directions hearings and the Inquest

48. Prior to the commencement of the Inquest, Directions Hearings were held on 24 November 2011 and 8 August 2012.
49. I granted leave for the following interested parties to be represented at the Inquest:

    a. The DHS;
    b. The TAC;
    c. Independence Australia;
    d. The RDNS; and
    e. The Metropolitan Fire Brigade.[23]

Issues investigated at Inquest

50. The main issues for examination at the Inquest concerned the circumstances in which Ms Currie's death occurred, and whether there were safety improvements that could be made to prevent similar deaths for persons with disabilities living in public housing. The areas of inquiry included:

    a. Whether any or adequate steps were taken to ensure the prevention and management of a fire emergency at Ms Currie's home, such as:
        - the conduct of a fire safety assessment or audit; and

[23] The MFB is a statutory authority set up by the *Metropolitan Fire Brigades Act 1958*. The MFB has a role in investigating fires (section 71 of that Act) and pursuant to the Victorian Fire Investigation Inter-Agency Agreement the MFB are expert cause and origin investigators for the Coroner.

- implementation of a plan to ensure the safe evacuation of Ms Currie from her home in the case of an emergency;

b. The operation and location of smoke alarms installed at Ms Currie's home and the systems in place for checking that the smoke alarms were in working order;
c. Whether a sprinkler system should have been installed at Ms Currie's home;
d. The effectiveness of the VitaCall PRU system in a fire emergency;
e. Whether Ms Currie's inability to access her wheelchair and/or open the front door impeded her ability to evacuate the home; and
f. Any other opportunities for safety improvements.

***Viva voce* evidence at the Inquest**

51. A six-day Inquest was held on 12, 13, 14, 15 and 18 March 2013 and 20 June 2013. Ms Karen Argiropoulos, barrister, was counsel assisting me.
52. *Viva voce* evidence was obtained from the following witnesses at the Inquest:
    a. Judith Anne Axford;
    b. Michael Anthony Ruyg;
    c. Sharlene Ruth Currie;
    d. John Desmond Kelleher;
    e. Rodney Graham East;
    f. Julie Faye Harris;
    g. Neil James Jenkins;
    h. Monique Destiny Rasch;
    i. Dr Guiseppe Joseph Toscano;
    j. Sharon McLachlan;
    k. Jennifer Elizabeth Sparks;
    l. Roberta Jean Buchanan;
    m. Vicki Nakos; and
    n. Barbara Hill.
53. At the conclusion of the evidence, I received a written outline of submissions from counsel on behalf of all interested parties. On 20 June 2013, the interested parties, through their respective legal representatives, made oral submissions in accordance with their outline of submissions. I

thank counsel assisting and the interested parties in this matter for their valuable contribution and submissions.

Lack of fire safety risk assessment(s) and evacuation planning for Ms Currie

54. A central issue in the Inquest focused on identifying the relevant party who should be responsible for conducting fire safety risk assessment(s) for Ms Currie whilst she was in her Home.
55. The evidence revealed that at no time, did any organisation involved in Ms Currie's care conduct a fire safety risk assessment in relation to her living arrangements, nor was there any planning as to how she could be evacuated in the event of a fire.
56. Evidence from persons responsible for various aspects of Ms Currie's care, around the time of her death, revealed serious gaps in the service providers' state of knowledge of her living arrangements and care needs, which resulted in less than optimal continuity of her care.
57. The fact that Ms Currie's surgery in May 2009 did not prompt the TAC and its contracted personal care service providers involved in her care to conduct an assessment of her needs to determine whether she required additional care or supports demonstrates the gaps identified in her care.
58. In so far as identifying fire risks to Ms Currie, several witnesses, funded by the TAC, gave evidence that they had identified that smoking in bed was a risk for Ms Currie. Dr Toscano gave evidence that he discussed these risks with Ms Currie constantly.[24] Ms Axford's evidence was that she had discussed the issue with Ms Currie.[25] Mr Ruyg, registered nurse with the RDNS, and other members of the nursing service also discussed the issue with Ms Currie.[26]
59. Vicki Nakos, Housing Services Manager at the DHS stated that, as far as she was aware, fire safety was not part of the design process when Ms Currie's Home was being planned; rather the focus was on her mobility requirements.[27]
60. TAC Support Co-ordinator Sharon McLachlan's (**Ms McLachlan**) evidence suggested that, from the TAC's perspective, there was no particular person or agency responsible for assessing Ms

[24] Transcript, page 281.
[25] Transcript, page 30.
[26] Transcript, page 63.
[27] Transcript, page 459.

Currie's fire safety in her home. However, Ms McLachlan expected whoever was working directly with Ms Currie would have discussed fire safety related issues with her.[28]

61. Occupational therapist Jenny Sparks' (**Ms Sparks**) evidence was that since Ms Currie's death, she now considers fire risk assessment as part of her role in assessing clients.[29] However, in her experience, fire safety is an issue that is rarely dealt with by occupational therapists undertaking home assessments.[30]

62. Independence Australia, as a service provider contracted by the TAC, did not have any processes or procedures in place for fire safety risk assessments for their clients. However, it did conduct hazard checks and safety audits focused on the health and safety of its staff attending a client's home.[31]

63. The RDNS also conducted risk assessments in client's homes; however, again these were primarily concerned with the health and safety of its staff. The RDNS submitted that it did not conduct fire risk audits *per se* and considered this to be a matter for the relevant professionals and not practicable for the RDNS in any event.

Overnight care for Ms Currie

64. A critical issue for the Inquest was how on 12 June 2009, Ms Currie found herself to be alone in her Home while confined to bed.

65. The evidence revealed that while some of the organisations involved with Ms Currie's care were aware that she was alone in her Home on a regular basis, this did not trigger a process by the TAC to reassess her care needs.[32]

66. It is concerning that there was no co-ordinated system for the TAC to be aware that Ms Currie was alone in her Home overnight.

67. Ms Axford's evidence was that she was aware Sharlene and Joshua Currie no longer resided with Ms Currie at the time of her death and she believed most organisations were under the impression that they were still living there.[33] Ms Roberta Buchanan (**Ms Buchanan**), Manager In-Home and Accommodation Services, Independence Australia stated that, as of May 2009, Independence

[28] Transcript, page 328-330.
[29] Transcript, page 406.
[30] Transcript, page 420.
[31] Transcript, pages 452-455 and Exhibits 30-32.
[32] Transcript, pages 23-24, 26, 55-56 and 276-277.
[33] Transcript, page 23.

Australia had a service co-ordinator attached to Ms Currie whereby care workers could report issues. However, there was no record that Sharlene moved out of the Home or that Ms Currie was home alone overnight while confined to bed.[34] Had it been a requirement that the service provider report such matters back to the TAC, the TAC would have been better placed to assess the client's care needs.

68. The DHS understood that Ms Currie was living by herself in her Home, having been informed that Sharlene had moved out, as required by its rent assessment processes.[35]

69. While Dr Toscano consulted with Ms Currie on the night before she died, it was his view that "*I felt her son was there most of the time, so I didn't think it was an issue.*"[36]

70. While the TAC stated that it was not aware that Sharlene had permanently moved out of Ms Currie's Home, there was some awareness that Sharlene had previously moved out and subsequently returned to the home.[37]

71. The TAC had funded the installation and monitoring of Ms Currie's VitaCall PRU on the basis of a report received from the RDNS stating that she had fallen and been left on the floor overnight because nobody else was at home to assist her.[38]

72. Ms Sparks' evidence was that she was not aware that Sharlene was no longer living at the home. Ms Sparks had previously, and consistently, recommended to the TAC that overnight care not be provided to Ms Currie because family members were at the Home overnight.

73. Ms Sparks' evidence was that had she been informed that Ms Currie was regularly alone overnight, she would have made significant changes to the care hours recommended, including recommending overnight care, which would have ensured Ms Currie was not alone overnight.[39]

74. Ms Sparks stated that, had Ms Currie refused an increased level of support,[40] she would have had to consider whether or not Ms Currie was safe to continue to live where she was absent of overnight care.[41]

75. Ms Sparks was also not aware of Ms Currie's confinement to bed following surgery in May 2009,[42] although she acknowledged that there were other times during Ms Currie's life when she

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[34] Transcript, page 432.
[35] Transcript, pages 460 and 465.
[36] Transcript, page 281.
[37] Transcript, pages 321 and 325.
[38] Transcript, pages 321 and 1381.
[39] Transcript, pages 381-382.
[40] Ms Spark's evidence was that had she had been aware that Ms Currie had been living alone that she would have recommended 16 hour care and inactive overnight care.
[41] Transcript, page 403.

was confined to bed for six weeks at a time.[43] Ms Sparks' evidence was that she would only have expected to be informed of Ms Currie's hospitalisation and surgery if there were any changes in Ms Currie's support needs as a result.[44]

76. The TAC wrote to Ms Sparks on 15 May 2009[45] requesting that she conduct an independent functional assessment of Ms Currie.[46] It appears from the contents of this letter and from Ms McLachlan's evidence, that there was no specific reason motivating this request, and it may have just have been initiated because it had been approximately one year since Ms Currie's last review.[47] The TAC's letter to Ms Sparks did not indicate that Ms Currie was to be hospitalised to repair pressure sores, that she had recently been hospitalised for mental health issues or that the review was urgent.[48] Unfortunately, Ms Sparks was not able to arrange an appointment with Ms Currie for the purposes of conducting this assessment prior to her death. Consequently, no new assessments of Ms Currie's needs were conducted in light of Sharlene moving out of the Home in December 2008 or in light of Ms Currie's recent hospitalisations.
77. Importantly, Ms Sparks' evidence was that had she known Ms Currie was alone at night she would have recommended the TAC fund overnight care.
78. Historically, all of Ms Sparks' recommendations to the TAC in relation to Ms Currie's care were approved and funded.

Case Managers

79. The TAC had a system in place for periodically reviewing its clients. This system was demonstrated by the fact that Ms Sparks had been directed to conduct an assessment of Ms Currie. However, this was not in response to any contemporaneous intelligence that Ms Currie was mostly living on her own and confined to bed.
80. Had the TAC had a 'case manager' system in place, these matters would have been known to them as they occurred and appropriate assistance and risk assessments for Ms Currie could have been implemented.

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[42] Transcript, page 423.
[43] Transcript, page 381.
[44] Transcript, page 380.
[45] Inquest brief, page 1399
[46] Transcript, page 376.
[47] Transcript, page 360.
[48] Transcript, page 360.

81. The TAC acknowledged that case management is appropriate in particular, in circumstances where complex care co-ordination is required. However, submissions on behalf of the TAC were that case managers were used, from time to time, to attend to a specific need or for a discrete goal, rather than for managing risk.[49]

82. Since 2009, the TAC has instituted changes including a reduction of the number of clients that a support co-ordinator has in their portfolio, allowing them to have contact that is more individual with a client, including face-to-face visits.[50]

Shifts not being filled by Independence Australia and adequacy of care services provided to Ms Currie

83. The evidence revealed that during 2009, a number of Ms Currie's carer shifts were not being filled, and she would often be left without a carer during evening shifts.

84. Ms Axford's evidence[51] was that if there was not a carer available, Independence Australia would not be able to fill the shift. Consequently, Ms Currie would be left without a carer for the evening shift approximately once per week. Ms Axford said that she frequently received a telephone call from Ms Currie at night time, advising her that no-one had turned up and asking for help.[52]

85. Ms Axford had been employed by Independence Australia as a Personal Care Attendant from 2001 and she cared for Ms Currie for approximately six years prior to her death. She was Ms Currie's most regular worker.

86. Sharlene said that she complained to Independence Australia about the failure to fill personal care shifts for her mother, without success.[53]

87. Ms Axford and Sharlene[54] both expressed concern that Ms Currie may not have taken her medication when carers did not attend.

88. Ms Buchanan explained that staff shortages at this time were due to a lack of available staff across the sector. Ms Buchanan's evidence was that the majority of Ms Currie's shifts were

[49] Transcript, page 509.
[50] Transcript, pages 508-509.
[51] Transcript, pages 20
[52] Transcript, page 20.
[53] Transcript, page 94.
[54] Transcript, pages 85, 87 and 94.

rostered out to agency staff from Care and Compassion and a small number were rostered to Ms Axford. Rosters produced by Ms Buchanan confirmed this synopsis.[55]

89. Ms Buchanan also stated that it was difficult to fill shifts for Ms Currie's care because a number of workers stated they did not wish to work with her due to difficulties experienced when caring for her.[56]

Ms Axford stated:

> *She wasn't the easiest person to get along with and she herself would sack carers. This would be due to her mental condition. She would abuse people which was really due to her mental condition. She would abuse me at times but I knew she didn't mean it and I knew how to deal with her. Some carers weren't able to deal with it and would leave.*[57]

90. Ms McLachlan's evidence was that she was advised by a nurse from the RDNS that shifts were not being filled by Independence Australia. As a result, she contacted Mr Neville Dane, Coordinator for Independence Australia (when it was ParaQuad) and was advised by him that carers had been attending and was provided with copies of timesheets.[58]

Whether there was a Skylight

91. Most of the fire damage was in Ms Currie's bedroom, which had major structural damage to the ceiling, roof and walls. The roof and ceiling had collapsed and the wall frames were deeply charred and completely consumed in places.

92. Initially, Mr Kelleher and SO East formed the opinion that there had been a skylight in Ms Currie's bedroom due to the apparent rapid spread of the fire to the roof. However, in response to Sharlene's evidence at the Inquest that there was no skylight in Ms Curries' bedroom or in the ensuite bathroom, SO East and Mr Kelleher accepted there was no skylight. SO East's evidence was "*The fact that the fire got up into the roof was our main reason for thinking that we had the skylight and on the morning some of the verbal conversation was the fire had got through the roof fairly quickly, which sort of supported that that was the reason why we had a skylight situation.* [59]

93. SO East and Mr Kelleher noted several other possibilities as to why the fire might have entered the roof as quickly as it did, including:

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[55] Transcript, page 430.
[56] Transcript, page 443.
[57] Inquest Brief, page 24.
[58] Transcript, page 327.
[59] Transcript, page 129.

a. the bed in the bedroom was elevated higher towards the ceiling;[60]
b. the existence of a tradesman type personal hatch into the roof space;[61] and/or
c. the construction of the ceiling itself.[62]

Smoke alarms in Ms Currie's Home

94. While there is no direct evidence that the smoke alarms activated on this night, this fortifies the need for alternatives to standard smoke detectors for people with complex needs such as Ms Currie.

95. Mr Kelleher's evidence was that while the venting of the fire into the roof space would improve a person's prospects for escaping the fire, it would also reduce the effectiveness of the smoke alarms.

96. Ms Currie's home was equipped with two Brooks PFS-ITL smoke alarms.[63] They were ionisation alarms, mains powered with a non-removable rechargeable lithium battery back up to ensure operation in the event of mains power failure.[64] They were located at the eastern and western ends of the hallway in accordance with the electrical plan for the Home.[65]

97. The installation of those alarms complied with the legal requirements applicable to the Home pursuant to the *Building Code of Australia 1996* and the *Building Regulations 2006* (Vic).[66]

98. Mr Kelleher's evidence was that the location of the smoke alarms were *"conventional"* and *"quite appropriate".*[67] However, in light of Ms Currie's tendency to smoke in bed, he considered it advantageous to install a different type of smoke alarm, such as a temperature rise alarm, rather than smoke, in Ms Currie's bedroom.[68]

99. SO East also considered the location of the alarms to be conventional, but because Ms Currie was confined to bed and was a chronic smoker, he thought it would have been prudent to have had a photoelectric smoke alarm in her bedroom.[69]

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[60] Transcript, pages 119- 120 and 130.
[61] Transcript, page 129.
[62] Transcript, page 130.
[63] Mr Van Ravenstein's statement Inquest Brief page 945 paragraph 15, SO East's evidence at Transcript, page 132.
[64] Mr Van Ravenstein's statement Inquest Brief, page 945 paragraph 15.
[65] Mr Kelleher's evidence Transcript pages 111, 113-114, , SO East's evidence Transcript pages 132, Exhibit 8 Plans of House Inquest Brief, page 207.
[66] Van Ravenstein statement Inquest Brief, page 945 paragraphs 11-16.
[67] Transcript, page 115.
[68] Transcript, pages 115-116.
[69] Transcript, pages 133-134.

100. I note the submissions of the DHS that had it been aware of Ms Currie's change in circumstances as a result of her surgery in May 2009, safety requirements could have been considered such as a temperature activated smoke alarm in Ms Currie's bedroom and any other safety systems that warranted implementing.[70]

101. The MFB recommends that smoke alarms are tested and dusted monthly.[71] Ms Currie, by reason of her paraplegia, would not have been able to test her smoke alarms.

102. I agree with Ms Julie Harris', (**Ms Harris**), Community Ageing Strategist and Community Resilience with the MFB evidence that clients who are unable to maintain a working smoke alarm should be identified and assisted with testing.[72]

103. Ms Axford's evidence was that it was not part of her duties to test smoke alarms. However, she personally may have changed the battery if this was required.

104. The smoke alarms in Ms Currie's home were maintained periodically by the DHS and also when electrical contractors attended the Home to perform other works.[73] However, the tenancy agreements between the DHS and residents rely on the tenant to regularly test that smoke alarms are working and report any faults to the DHS. This is consistent with the *Residential Tenancies Act 1997*. However, application of the *Residential Tenancies Act 1997* in this regard does not seem appropriate. The standard agreement between landlord and tenant when considered in the context of Ms Currie's (and presumably other DHS clients') circumstances and functional limitations is, at best, unfair and realistically unworkable.

105. Independence Australia was not contracted by the TAC to undertake maintenance works at the Home. Despite this, Ms Buchanan's evidence was that Independence Australia conducted hazard checks or home/site audits annually. Ms Buchanan stated a review of Ms Currie's file revealed documentation evidencing that site audits, for staff safety and not the client's, were conducted in 2001, 2002, 2004 and 2005.[74]

106. Independence Australia's processes also included provision for carers to report matters through their Incident and Hazard Reporting procedure. A report could be either filled in by a carer or telephoned through to the office and a staff member filled out the Incident/Hazard/Near Miss Form. The form would be processed by the office team, who assessed the incident and

[70] Transcript, page 515.
[71] Transcript, page 189.
[72] Transcript, page 189.
[73] Statement of Andrew Demicoli and evidence of Nakos at Transcript, pages 461-464.
[74] Transcript, page 433 and Exhibits 30 and 32.

implemented corrective action. It was also logged on the Occupational Health and Safety register and also monitored by the Health and Safety team to ensure Independence Australia closed the loop on all corrective actions. Ms Currie's file did not contain any Incident/Hazard/Near Miss forms.

107. Ms Harris suggested that high-risk clients such as Ms Currie should have personal monitored alarm systems installed in their homes linked to the smoke alarms. If activated, a message is communicated to the monitoring company, who then contacts the client who owned the personal pendant alarm. There is merit to this suggestion.

108. The evidence was that Ms Currie's VitaCall PRU did not have the capability to be linked to the smoke alarms. However, other systems were available from various companies including Tunstall, Safety Link and INS Group.[75]

Domestic sprinkler systems

109. SO East gave evidence that Ms Currie's Home would have benefited from the installation of a domestic sprinkler system, which would have given her a better chance of evacuating from the fire.[76]

110. I agree with the MFB submissions that the decision whether to install a domestic sprinkler system should only be required after an individualised fire safety risk assessment is conducted. Where such an assessment indicates the need for additional fire safety measures, active consideration should be given to employing strategies to mitigate the risk of death or injury by fire.

111. Had such a risk assessment been undertaken in this case, I am confident a person such as Ms Currie who presented with risk factors of paraplegia, mental health impairment, history of smoking in bed and living alone outweighed the estimated installation and maintenance costs submitted by the DHS and the MFB of installing a domestic sprinkler system.

112. I also agree with Dr Toscano who emphasised the importance of protecting people with quadriplegia and paraplegia who live alone, often by choice. Dr Toscano stated that he had over 250 quadriplegic and paraplegic patients, only three of whom had sprinklers installed in their homes.[77]

[75] Transcript, pages 200-204 and Exhibit 15.
[76] Transcript, page 140.
[77] Transcript, pages 291-292.

113. As of 20 June 2013, the TAC had approximately 244 paraplegic claimants and 200 quadriplegic claimants and it was their submission that domestic sprinkler systems could potentially be cost prohibitive. The TAC submitted:

> *...at the very highest, if one took the highest figure from the DHS estimate and multiplied it out just as a straight mathematical calculation for over 400 people that's over $30 million. Similarly, those sorts of maintenance issues are over two million per annum and it's not suggested that anyone wants to penny-pinch or anything like that but one has to look at financial ramifications of these sorts of matters but the commission will engage independent contractors to assess the costs of installation of fire safety equipment where the question arises in individual circumstances rather than saying overall it will be appropriate in every case and also, Your Honour, there may well be many houses that have appropriate fire safety provision already but that is another ongoing matter.*[78]

114. I did not find the estimate of costs submitted by the TAC helpful. The estimated costs provided did not identify how many of those clients live in their home alone. The estimated costs were meaningless in the context of Ms Currie's death. The TAC need to undertake individualised risks assessments for each client. They will only then know the true cost of minimising fire risks and preventing like deaths, such as Ms Currie's death.

115. Service providers, such as the TAC, should incorporate into their individualised client risks assessments whether the installation of a domestic sprinkler system is necessary for minimising fire risks.

116. I, however, commend the TAC's submissions that it "*will consider the installation of appropriate fire safety equipment on an individual basis obviously for the same reasons that has to be assessed on an individual basis, the commission currently funds home modification for appropriate people and fire safety equipment may necessarily form part of those modifications based on the individual circumstances.*"[79]

117. The DHS submissions detailed that it already has in place a number of processes for tenants to request modifications to the DHS owned properties. The Application for Special Accommodation Requirements[80] is one particular way in which a DHS tenant could request special accommodation

[78] Transcript, pages 510-511.
[79] Transcript, page 509.
[80] Inquest brief, page 990.

modifications. The DHS, in its submissions, advised that the Director of Housing is updating this form to prompt those filling out the form to specifically consider the risk of fire.[81]

Automatic doors

118. SO East further opined that Ms Currie's home would have benefitted from the installation of an electronic interlocking system, which would allow the resident to flick a switch to release the front and back doors of the property. Such a system could both unlock the doors and cause the doors to open.[82]

119. Again, service providers, such as the TAC, should incorporate into their individualised client risk assessments whether the installation of an electronic interlocking system for safe egress is necessary for minimising fire risk.

Fire safety information and training for carers and other service providers engaged by the TAC

120. Alarmingly, none of the people involved in Ms Currie's care had received formal education and/or training in relation to fire safety.

121. Independence Australia, as a registered training organisation and accredited provider of training, required, and funded, its in-home carer employees to be qualified at Certificate III and/or Certificate IV level In Home and Community Care; Disability and First Aid.[83] While Independence Australia has its own internal policy that its carers have, at a minimum, Certificate III level for In Home and Community Care and Disability, the evidence of Ms Buchanan was that separate and additional ongoing or refresher training concerning fire safety was not provided by Independence Australia.[84]

122. As at the time of Ms Currie's death, the Certificate III and IV training modules did not include specific fire evacuation training, but covered hazard training in the Occupational Health and Safety accredited unit of those certificates. However, it was general and not specific to environments such as a client's home.

123. The MFB informed me that basic home fire safety training materials had been developed and embedded into the national training for a range of community care workers. Consequently, since

[81] Transcript, page 518.
[82] Transcript, pages 140-141.
[83] First Aid Training is conducted annually.
[84] Transcript, page 434.

2010, newly trained workers in the community care sector were provided basic home fire safety training.[85] Ms Harris' evidence was that since December 2009, the MFB produced Basic Fire Safety Training packages for imbedding as a unit of study into 49 national qualifications pertaining to community care. In addition, the MFB have made the training materials available to registered training organisations and community service organisations for the training of their staff.[86] Further, the MFB was developing more comprehensive fire safety training for professionals or senior community workers, including occupational therapists.[87]

124. I agree with the MFB concerns that despite the success of this project, not all workers employed in the community care sector undertake formal basic home fire safety training to attain the qualifications contained in these training packages and many workers will have completed formal training prior to 2010.

125. This gap in training in the community care sector is evidenced by the fact that Ms Axford completed her Certificates III and IV in 'Disability' prior to 2010 and did not receive any induction or skills maintenance training on fire safety while working for Independence Australia.

126. Nor was it a mandatory requirement by the TAC that its contracted care providers ensure their employees who undertake in-home care have recognised training such as Certificate III and/or IV for In Home and Community Care and/or Disability.[88]

127. Ms Harris' evidence was that an allied health worker such as an occupational therapist, in circumstances such as those Ms Currie faced, was well placed to conduct fire risk assessments and emergency planning for individual clients.[89] Similarly, Ms Harris' evidence was that in-home care workers could also play a role in identifying clients who may be at increased risk due to behaviours such as smoking, and promote or assist with strategies to reduce their risk and reiterate a client's emergency plan.[90]

128. I agree with the MFB's submission that in order to overcome the gap in training in basic home fire safety, the training materials must be mandatory as part of the induction processes for all new workers and as part of skills maintenance/refresher training for existing workers who provide in-home care.

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[85] Report of Ms Harris.
[86] Transcript, pages 180-183.
[87] Transcript, pages 184-185.
[88] Transcript, page 527.
[89] Transcript page 191.
[90] Transcript, page 191.

129. I also agree with the MFB's submission that service agreements with providers should stipulate that their workers be required to go through the basic home fire safety training. This would ensure all services indirectly provided by organisations through brokerage could be delivered by workers who have an increased awareness and understanding of basic home fire safety.[91]

130. I also agree with Ms Harris' evidence that funding agencies which manage service agreements, such as the TAC, that broker the actual rendering of services to preferred providers, should play a role in ensuring that basic fire safety assessment policies, processes and training are implemented by the service providers they engage.[92]

131. The evidence of Ms Barbara Hill, Senior Manager at the TAC and WorkSafe, also supported the MFB's position in that the TAC sets the expectations around the commercial arrangements with service providers and fire safety related measures are capable of being included. It is a common sense approach and one that should be adopted by the TAC, if it has not already done so.

132. I commend the MFB's commitment to working with the TAC and other entities involved in the funding or provision of in-home care to effect systemic improvements relating to fire risk in the home and the development of fire risk assessment policies and procedures.

133. Ms Harris stated that, following the death of Ms Currie, she made contact with Independence Australia to offer free fire safety training to its workers, however this offer was declined.[93] Ms Harris also contacted the TAC with the view to working on how it could ensure that its service providers had a consistent level of knowledge regarding fire safety, however, at that time, these discussions did not progress.[94]

134. I note that since 18 March 2013, the MFB Community Resilience and the TAC Health Services Group met to progress the issue of fire safety for the TAC's clients. The first meeting occurred on 26 March 2013 with the primary focus being to develop increased inter-agency knowledge and scope a range of issues related to the fire safety of the TAC's clients. A second meeting was held on 22 April 2013 for the MFB Community Resilience Workplace Emergency Management to examine fire safety in Supported Residential Services and other care settings being explored/developed/utilised by the TAC. I commend the MFB's commitment to working with the TAC to progress discussions relating to fire safety for the TAC's clients

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[91] Transcript, page 246.
[92] Transcript, pages 186-187.
[93] Transcript, page 253.
[94] Transcript, page 254.

135. I also commend the TAC for its submission that it is considering how it can distribute basic fire safety information to high-risk TAC clients through its service providers and the internet.[95] The TAC, through its legal representatives, advised that it was reviewing its service agreements and as part of that review, would consider how to make basic fire safety training mandatory for all of its service providers.[96]

The placement of Ms Currie's wheelchair away from her bed

136. Ms Currie's wheelchair was located in the ensuite, some four metres from her bed.[97] Ms Axford explained that she had been instructed by the hospital or the RDNS to keep Ms Currie's wheelchair away from her bed so that Ms Currie would not get out of bed and aggravate the healing of her wounds. Ms Axford was not able to say with any certainty who provided the direction about the placement of the wheelchair. Her evidence was "*...originally I think [it] came from Dandenong Plastics ... and passed on to Royal District...It might've been one of the nurses from Royal District that conveyed it to us*",[98] and "*I really can't remember exactly where it, where the message came from. I think it would've originally come from Dandenong Plastics, who would've conveyed it to probably the nursing staff that were to come in and do the wound repairs. And I can't remember whether Independence Australia actually told us as well ...*"[99]
137. Ms Buchanan's evidence[100] was that there is no evidence in the Independence Australia file that there was a direction to remove Ms Currie's wheelchair from her range. Moreover, her evidence was that she would be quite uncomfortable with such a direction, and that if a hospital had requested her to do that, she would advise them that she could not comply.
138. Mr Ruyg gave evidence that he had no knowledge of the direction to remove the wheelchair, and expressed surprise that a decision like this, which deprived Ms Currie of important rights, would have been made without consultation with her occupational therapist.[101]
139. Ms Sparks was also unaware of the direction and while she could understand something like this being said if there was someone else in the home with Ms Currie, it was "*quite negligent*" when

[95] Transcript, page 503.
[96] Transcript, pages 469 and 505.
[97] Transcript, page 143.
[98] Transcript, page 22.
[99] Transcript, pages 22-23.
[100] Transcript, page 446.
[101] Transcript, pages 63-64.

nobody else was at home "*because obviously if somebody's wheelchair dependent and they're by themselves they've got to be able to get out of bed and get out of the house.*"[102]

140. Dr Toscano expressed a similar view in part[103] that while he was not aware of the direction to leave the wheelchair away from the bed, he could understand such advice being given in circumstances where she was recovering from major pressure area surgery. Further, he gave evidence that had she tried to get out of bed by herself with the use of her wheelchair she could potentially impact her healing process leading to a longer healing time.[104]
141. Further enquiries by the RDNS revealed no evidence to support any suggestion that the RDNS instructed care staff of another organisation (or its own staff) to remove the wheelchair from the range of the bed.
142. The fact that Ms Currie was not able to access her wheelchair clearly contributed to her not being able to escape the fire in a timely manner.
143. However, despite a thorough investigation into the reason(s) for the wheelchair being placed away from Ms Currie's reach, I am unable to make any definitive finding as to who provided this instruction or why it was done. This further supports the need for persons such as Ms Currie to have continuity of care and a fire safety risk assessment undertaken.

Preventative measures since Ms Currie's death

144. Ms Currie's tragic death is an example of the increased risk of death by fire in the community care sector.
145. The MFB advised that nationally, there are nearly 900,000 older people living with a disability who receive in-home community care, with this figure expected to rapidly increase.
146. In 2011, the MFB commissioned a review of fatal fires in the Metropolitan Fire District between the financial years of 2000 and 2010 (**The Review**)[105] and examined the involvement of older people and people with disabilities. The Review identified 62 preventable[106] residential fire fatalities, and had the following findings:

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[102] Transcript, pages 383-384.
[103] Transcript, page 282.
[104] Transcript, page 294.
[105] Aufiero, M., Carlone, T., Hawkins, W. and Murdy S. 2011. *An Analysis of Preventable Fire Fatalities of Older People and People with Disabilities: Risk Reduction Advice for the Community Care Sector.* The determination of age and disability was established using Fire Investigation Reports.
[106] *Preventable* was defined as a fire that was started *accidently* (unintentionally).

a. older people (65+) and people with disabilities had an increased risk of fire fatality, making up 66% (n=41) of all fatalities;
b. people aged 65 and older were 3.7 times as likely to be a fire fatality than the general population;
c. people with a disability were 4.2 times as likely to be a fire fatality than the general population;
d. smoking materials were the leading cause of preventable residential fires, accounting for 34% (n=21) of fatalities;
e. the most common room of origin in fatal fires was the bedroom, accounting for 46% (n=28) of fatalities;
f. most homes did not have working smoke alarms, with 58% (n=36) of fatalities occurring in homes with a non-existent or non-functioning smoke alarm;
g. most fire fatalities occurred at night, with 69% (n=38) of fatalities occurring between 8.00pm and 8.00am;
h. 63% (n=36) of all fire fatality victims lived alone, which made people who lived alone 7.1 times as likely to be a fire fatality than the general population;
i. 19% (n=12) of fatalities were known to be hoarders; and
j. at least 35% (n=22) of fatalities were smokers.

147. The Review also undertook a detailed qualitative analysis into six fatal fires involving community care clients to determine the key high-risk features of each incident. This analysis identified:
a. smoke alarms were not always present and could have helped alert the occupant or neighbours to the fire emergency, which could have helped notify emergency services more quickly;
b. failure to be alerted to the fire reduced the time that the occupant had to respond;
c. each individual has unique needs and identifying the specific fire risks for each person can help in preventing fires; and
d. failure to quickly notify emergency services was a large factor that contributed to the fatality.

148. The relevant recommendations of the Review were:

a. all rooms in which a client smokes be fitted with a stand-alone photoelectric smoke alarm with a ten year long-life battery, as opposed to ionisation smoke alarms;[107]
b. smoke alarms be interconnected[108] and linked to personal alarm pendants;[109]
c. all rooms in which a person smokes have a heavy-high sided ashtray placed on a stable non-combustible surface;
d. if the person smokes in bed, use of flame retardant bedding and/or flame retardant mattresses;
e. personal alarms for older clients that allows them to call for help to a control base with a neighbour or family member listed as the emergency contact;
f. for clients with limited mobility, walking aids or wheelchairs should be left near their bed each night;
g. educate clients who have experienced fire incidents previously on the dangers related to the high risk behaviour of smoking in bed, and educate clients on proper safety methods to avoid the same happening again; and
h. where burns from previous fires are detected in combination with other risk factors, sprinkler systems or a portable sprinkler system should be installed in rooms where the fire risk is high for the client.

149. I agree with the MFB's submissions that the risks for this group are significant where:

a. community care workers are not required to have any specific training;
b. basic home fire safety training is not mandated for carers by the service providers and funders through qualifications, induction or skills maintenance training;
c. there is no risk assessment process inclusive of fire risk, to assist a carer to identify high risk behaviours or environments;
d. a community care client's lack of mobility and/or cognition prevent maintenance of a working smoke alarm without assistance;
e. there is no discussion and planning with community care clients in relation to what to do in a fire or other emergency;

[107] Recommendation 1 and transcript pages 134-138.
[108] Recommendation 3 and transcript page 232.
[109] Recommendation 4 and transcript pages 200-204. I note that the MFB provided brochures for this technology during the Inquest.

f. the community care client is considered high risk (as was the case with Ms Currie) and there is no case manager to coordinate the client's range of services and to mitigate this high risk; and

g. specific actions to mitigate against fire safety concerns have not been implemented.

Recommendations in the Finding of Audrey Svikers

150. Since Ms Currie's death, Coroner Spooner made recommendations in her findings dated 15 November 2012 following the Inquest into the death of Audrey Svikers. The relevant recommendations are:[110]

a. Svikers recommendation 3: That community care providers promote regular testing and maintaining of smoke alarms to the client, their family and/or friends or provide assistance for their clients to test and maintain smoke alarms if required; and

b. Svikers recommendation 4: In homes where the client smokes, community care providers promote the use of high-sided ashtrays or sealed containers to allow for properly discarded smoking materials.

151. I support these recommendations and note that the DHS's response to recommendation 3 was that it was still considering its position because it was not known if the changing of batteries and installation of battery smoke alarms was routine practice across all service providers.

152. The DHS response to recommendation 4 was that it had implemented this recommendation and the emergency planning and home fire safety section of 'Strengthening assessment and care planning: a guide for HACC assessment services' (Department of Health, 2010) provides guidance for assessors in regard to promoting a safe home environment for chronic smokers. This includes checking that there are working smoke alarms and promoting the use of heavy, high sided ashtrays. The implementation of the recommendation was also evidenced in a number of its publications.

153. The TAC's response to recommendations 3 and 4 acknowledged that fire safety is an important safety concern in the disability sector and that it was working with the MFB and the DHS Fire Risk Management Unit to exchange information and expertise about fire safety issues.

[110] COR 2008 2158.

154. The TAC distributed Coroner Spooner's recommendations to all contracted and non-contracted disability services providers it funded to provide supported accommodation and/or attendant care services to clients and injured workers in the last two years.

Recommendations in the Finding of Pearl Recht

155. Also since Ms Currie's death, Deputy State Coroner West made recommendations in his findings dated 6 December 2012 following the Inquest into the death of Pearl Recht.[111]

156. I agree with, and support, Deputy State Coroner West's recommendations to agencies that fund programs for 'in-home' service providers to older people in Victoria, The relevant recommendations were:

    a. Recht recommendation 1(a): That the 'Basic Home Fire Safety Training Materials', as endorsed by the Australasian Fire and Emergency Service Authority Council, are mandated for use by community aged care providers in Victoria, through inclusion of the information into the induction processes for new community aged care workers. These materials should also be used for skills maintenance sessions/programs conducted by community aged care providers for existing workers.

    b. Recht recommendation 1(b): That basic home fire safety is incorporated into policy and practice guidelines for assessment processes used to assess older people for 'in home' services. In residences where the client is considered at greater risk due to health or lifestyle factors (as defined in Essential Knowledge: Basic Home Fire Safety, Section 2), additional smoke alarms should be installed to provide the earliest possible warning of a fire for the occupant.

157. The Department of Health and Ageing (Commonwealth) in responding to these recommendations accepted that service providers, through appropriate risk management strategies, may help to reduce the number of preventable fire fatalities involving older people who receive 'in-home' support to assist them to live in the community.

158. On 1 February 2013, the Department of Health and Ageing released an Alert (**Annexure A**) to all Australian Government subsidised providers of home care services to make them aware of Deputy

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[111] COR 2011 3161.

State Coroner West's recommendations. The Alert also contains reference to the complementary recommendations made by Coroner Spooner on 15 November 2012 in relation to the death of Audrey Svikers.

159. The DHS, being an entity responsible for funding in-home care services pursuant to the Home and Community Care (**HACC**)[112] Program, in responding to these recommendations acknowledged that there is a need to identify common risk features and to deliver an improved safety outcome for older people and people with disabilities.

160. The DHS implemented an alternative to Deputy State Coroner West's recommendation 1(a) that an appropriate Certificate III level qualification would be the minimum standard of qualification required in Victoria for HACC Program funded community care workers (Department of Health HACC Community Care Worker Training Qualifications, July 2010).

161. The 'Basic Home Fire Safety Training Materials' developed by the MFB and the Australasian Fire and Emergency Service Authority Council (AFAC) is the material included in compulsory units of competency for a Certificate III level qualification. This includes an understanding of the need for smoke alarms and is focussed on both the occupational health and safety aspects of community service work, but also the duty of care to clients. As an alternative to mandating particular materials, the HACC program now recommends that service providers consider using the 'Basic Home Fire Safety Training Materials' (as appropriate) for new and existing staff. In relation to the skills maintenance sessions conducted by community aged care providers for existing workers, the HACC program is exploring with the new state-wide Education and Training Service, whether Basic Home Fire Safety using the training materials recommended by the coroner can be promoted through the HACC training calendar.

162. In relation to Deputy State Coroner West's recommendation 1(b), the DHS was still considering its response.

[112] The HACC Program is jointly funded by the Commonwealth and Victorian governments. The Commonwealth has responsibility for national policy development and the state has responsibility for day-today administration. The Department of Health, Ageing and Aged Care Branch is responsible for managing HACC in Victoria in accordance with the national guidelines. HACC funded organisations are responsible for managing and operating their services so as to ensure compliance with HACC policies, quality standards, guidelines and other requirements.

COMMENTS pursuant to section 67(3) of the ***Coroners Act 2008***

163. I make no adverse comments about any individuals involved in Ms Currie's care. However, there were shortcomings identified in the management of Ms Currie's care by some of the organisations that provided her with in-home care.

164. These shortcomings, while not directly related to the cause of the fire, contributed to the circumstances in which Ms Currie found herself when she caused a fire to occur in her home.

165. In particular, the shortcomings were relevant to circumstances Ms Currie found herself in when she was unable to obtain immediate assistance and/or leave her home safely.

166. There is clear and cogent evidence of a lack of knowledge of Ms Currie's true and contemporaneous circumstances immediately before her death, reflecting a lack of a holistic approach to her care.

167. Nothing said in this Finding about Sharlene and Joshua not living at or being in the Home should be construed as a criticism of them.

FINDINGS

168. I find that the identity of the deceased was Cheryl May Currie, born on 8 September 1969 and her death occurred on 12 June 2009 at 3 Lonsdale Avenue, Hampton East.

169. I accept and adopt the conclusions of Dr Baker and I find that Cheryl May Currie's death was due to smoke inhalation. I also accept that her paraplegia contributed to her death to the extent that it contributed to her inability to escape the fire.

170. I accept and adopt SO East's expert evidence and find that the most probable cause of the fire to be *"the imprudent use of smoking materials whilst the occupant was incapacitated in bed."*[113] Both Mr Kelleher and SO East concluded that the point of origin of the fire started on or adjacent to the bedside table on the south (right) side of the bed and the burn patterns indicated a higher level fire,[114] initially starting as a smouldering fire before breaking into flame and combustion.[115]

171. There is no evidence to suggest that the fire was deliberately or intentionally lit and the inference is available to me that the fire was an accident. Supporting this inference is an absence of evidence that Ms Currie intended to take her own life on 11-12 June 2009.

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[113] Report of SO East included in X9.
[114] Report of SO East included in X9 -refer to Note 4.
[115] Transcript, pages 107- 108, 126 and 193.

172. Without diminishing the importance smoke alarms have to minimise the risks related to fires, there is no evidence to suggest that Ms Currie's death was caused by or in any way related to the failure of the smoke alarms installed in her home.

173. The smoke alarms were located at both ends of the main hallway, one was found to be working correctly, while the other was damaged beyond testing. It is not possible for me to make a finding as to whether either smoke alarm activated in response to the fire. However, I find the systems in place for the testing of the smoke alarms to ensure that they were operating correctly was inadequate.

174. I agree with counsel assisting that the TAC, as the funding organisation of the majority of the services provided to Ms Currie, ought to be responsible for ensuring that fire safety risk assessments were conducted on an ongoing basis by the care providers it engaged.[116]

175. I find that had the TAC conducted, or caused a risk assessment to be conducted for Ms Currie as a result of her May 2009 hospitalisation, it would have identified that at the time of her death, that she required overnight care.

176. I also find that had any service provider conducted a fire safety risk assessment it would have identified that Ms Currie was a high fire risk and had an inadequate evacuation plan.

177. I agree with Ms Sparks' suggestion that the TAC pro-forma "Occupational Therapist – Functional Independence Review" be amended to clearly identify the need for the therapist to consider whether the client's fire risks have been assessed, and whether there are fire safety related issues that need to be further assessed or followed up.[117]

178. I find that there is no evidence to suggest that Ms Currie's death was caused by or in any way related to difficulties with shifts being consistently filled by agency carers.

179. I agree with the MFB submission that the TAC should review its service delivery model to give consideration to use of case managers for the TAC's community care clients with complex high care needs.

180. I also agree with Ms Harris' evidence that care workers are a service provider's "*eyes and ears*" and have direct knowledge of the client's day-to-day activities and risk factors. They are best placed to report relevant matters to a client's case manager for further assessment or action.[118]

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[116] Transcript, page 538.
[117] Transcript, pages 423-424.
[118] Transcript, pages 192-193.

181. I find that the TAC service delivery model did not use case managers for the TAC's community care clients with complex high care needs. Dr Toscano, who I found to be a compelling and impressive witness, appropriately highlighted the importance of continuity of care:[119]

> *when somebody's like Cheryl, where she's an exceptionally difficult person who's got multiple issues ... you need that continuity of care, you need those carers who can be placed somewhere else so they don't lose income. And then come back into the home, because they know the person – they get to know the person and they do things with the person.*[120]

182. I find the circumstances that Ms Currie found herself in after being discharged from hospital in May 2009 up until her death were due to a lack of communication, assessment and co-ordination of services having regard to her changing needs. There is no doubt that, at the time of Ms Currie's death, her risk profile, in relation to death by fire, was high because of her chronic smoking, confinement to bed after surgery and spending most nights at Home alone.

183. I find that Ms Currie's inability to access her wheelchair contributed to her inability to be able to escape the fire in a timely manner and thus her succumbing to the effects of smoke. However, I am unable to make any definitive finding on how her wheelchair came to be placed away from her direct access.

184. I find that at the time of Ms Currie's death, there was a significant gap in training in basic home fire safety for community care workers and providers.

185. I find that funding agencies, such as the TAC, play a significant role in ensuring that fire safety assessment policies and processes are implemented by the service providers they engage.[121] For organisations such as the TAC that service case managers and broker the actual rendering of services to other providers, I agree with the MFB that service agreements with providers should stipulate that their workers be required to go through the basic home fire safety training. This would ensure all services indirectly provided by organisations through brokerage could be delivered by workers who have an increased awareness and understanding of basic home fire safety.[122] The evidence of Ms Barbara Hill, Senior Manager at the TAC and WorkSafe, also supported the MFB's position in that the TAC sets the expectations around the commercial

[119] Transcript, page 306.
[120] Transcript, page 292.
[121] Transcript, pages 186-187.
[122] Transcript, page 246.

arrangements with service providers and that fire safety related measures are capable of being included. It is a common sense approach and one that should be adopted by the TAC, if it has not already done so.

186. I make no adverse finding against any of the individual clinicians who provided care for Ms Currie, as the weight of the available evidence does not support a finding that they departed from the prevailing standards of their respective professions. Rather, the circumstances surrounding Ms Currie's death necessitated examination of systemic issues regarding the provision of in-home care in Victoria.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendations connected with the death:

Recommendation 1

In supporting and recognising the importance of the recommendations made by Deputy State Coroner West and Coroner Spooner, I recommend to the agencies identified in this matter,[123] being the DHS, the TAC, the National Disability Insurance Agency and Independence Australia, that the 'Basic Home Fire Safety Training Materials', as endorsed by the Australasian Fire and Emergency Service Authority Council, are mandated for use by all of their in-home disability care providers through inclusion of the information into the induction processes for new care workers. These materials should also be used for skills maintenance sessions/programs conducted by care providers for existing workers.

[123] While I note the existence of many other care providers in Victoria relating to the disability sector and other relevant sectors, such as aged care and youth disability, I note that a broad ranging recommendation to other such agencies would be beyond the scope of this Inquest. I would however encourage the dissemination of this information and recommendation to all relevant stakeholders and in-home care providers.

Recommendation 2

I recommend, the TAC, if it has not already done so, ensure that its community care clients with complex high care needs, both new and existing, are the subject of individualised risk assessments to identify fire safety risks and where necessary develop a fire safety emergency plan with specific actions to take in response to fire safety concerns associated with high risk behaviours. Such risk assessments must include, but not be limited to, ensuring the following matters are addressed:

- all rooms in which a client smokes be fitted with a stand-alone photoelectric smoke alarms with a ten year long-life battery, as opposed to ionisation smoke alarms;[124]
- all smoke alarms are subjected to a clear testing regime and the person responsible for the testing to be clearly identified;
- smoke alarms be interconnected[125] and linked to personal alarm pendants;[126]
- a review of the operational capacity of personal alarms in place for (or to be provided to) complex high care needs clients to ensure the personal alarms allow the client to call for help to a control base with a neighbour or family member(s) listed as the emergency contact(s);
- all rooms in which a person smokes have a heavy-high sided ashtray placed on a stable non-combustible surface;
- if the person smokes in bed, use of flame retardant bedding and/or flame retardant mattresses;
- for clients with limited mobility, mobility aids or wheelchairs should be left near their bed each night;
- educate clients who have experienced fire incidents previously on the dangers related to the high risk behaviour of smoking in bed and educate clients on proper safety methods to avoid the same happening again; and
- where burns from previous fires are detected in combination with other risk factors, sprinkler systems or a portable sprinkler system should be installed in rooms where the fire risk is high for the client.

[124] Recommendation 1 and transcript pages 134-138.
[125] Recommendation 3 and transcript page 232.
[126] Recommendation 4 and transcript pages 200-204. I note that the MFB provided brochures for this technology during the Inquest.

Recommendation 3

I recommend the TAC develop fire risk assessment policies and procedures to be used to assess and address the fire risks to the TAC's clients, and in particular, for clients who may be at increased risk of fire fatality due to impaired mobility, such as paraplegia or quadriplegia, resulting from a transport accident. Such policies and procedures should include the following:

- The provision of basic information regarding fire safety in the home and evacuation planning to the TAC's clients;
- Development of an assessment process that is inclusive of assessment of fire risk.
- Amend its pro-forma "Occupational Therapist – Functional Independence Review" form to clearly identify the need for the therapist to consider whether the client's fire risks have been assessed, and whether there are fire safety related issues that need to be further assessed or followed up
- Identify clients who may be at increased risk due to impaired mobility and behavioural factors such as smoking, and promote or assist with strategies to reduce their risk;
- Identify clients who are unable to maintain a working smoke alarm without assistance and ensure that service providers assist with testing;
- Ensure that service providers develop and discuss evacuation and emergency plans with clients who experience impaired mobility.

Recommendation 4

I recommend the TAC review its service delivery model for its clients to give consideration to use of case managers.

Recommendation 5

I recommend the TAC include in their service agreements with all brokered in-home service providers, that their workers will have undertaken education in relation to the Basic Home Fire Safety Training Materials. Also, that the service agreements with all brokered services providers include the

requirement to use the training materials in the induction of new workers and skills maintenance of existing workers.

Recommendation 6

I recommend that the TAC require all of its service providers to provide Basic Fire Safety Training to their workers. This could be done by amending the relevant service provider contracts to include a requirement that workers have undergone such training.

Recommendation 7

I recommend that the DHS include fire risk assessment as part of its processes in planning and building new homes, particularly when homes are custom built for persons with impaired mobility.

Recommendation 8

In addition to the DHS procedure that allows a tenant to request modifications to properties it owns (i.e. Application for Special Accommodation Requirements),[127] I recommend that the DHS and the TAC collaboratively review its processes to ensure all TAC clients in the DHS accommodation with paraplegia and quadriplegia are identified. Once identified, the TAC ensure individualised risk assessments are conducted in relation to fire safety equipment needs and consider installing additional smoke alarms, sprinkler systems, automated doors and/or monitored alarm systems linked to smoke alarms in appropriate cases. The TAC notifies the DHS of its assessment.

Recommendation 9

I recommend that the TAC and the MFB develop a protocol between the agencies to ensure there is ongoing collaboration with respect to fire safety for the TAC's clients.

Pursuant to section 73(1) of the Coroners Act 2008, I order that this Finding be published on the internet.

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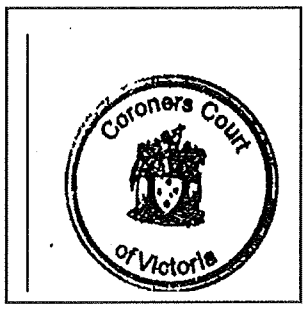
[127] Inquest brief, page 990.

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

- Ms Sharlene Currie
- The Metropolitan Fire Brigade
- The Secretary to the Department of Health and Human Services
- The Transport Accident Commission
- The Royal District Nursing Services
- Independence Australia
- Dr Guiseppe Toscano
- VitaCall
- WorkSafe Victoria
- Martin Foley MP Minister for Housing, Disability and Ageing, Minister for Mental Health
- Steven Herbert MP Minister for Training and Skills
- Laurie Harkin, Disability Services Commissioner of Victoria
- Colleen Pearce, Public Advocate
- David Bowen, Chief Executive Officer, National Disability Insurance Agency
- Detective Senior Constable Luke Walsh, coroner's investigator.

Signature:



AUDREY JAMIESON, CORONER

28 August 2015