INQUEST FINDINGS, COMMENTS AND RECOMMENDATIONS into Fire and Nine Deaths at Kew Residential Services on 8 April 1996

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INQUEST FINDINGS, COMMENTS AND RECOMMENDATIONS into Fire and Nine Deaths at Kew Residential Services on 8 April 1996

Held at the Coronial Services Centre, Southbank, between 14 October 1996 and 28 April 1997 (81 days of sitting), and on site at Kew Residential Services on 14 October 1996 and 18 March 1997.

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CONTENTS

INTRODUCTION 10

CONCLUSION TO FINDINGS, COMMENTS AND RECOMMENDATIONS 12

THE FINDINGS 13

PART 1 THE FIRE, ITS AFTERMATH AND CAUSE 14

1.1 The Deaths 14

1.2 Summary of the Circumstances of the Fire 14

1.3 History of KRS, its Environs and the Nature of its Residents and Staff 15

1.4 Residents and Staff at 'Building 37' during the Fire 17

1.4.1 The Deceased 17

1.4.2 The Survivors 19

1.4.3 Use of Therapeutic Drugs for Management of Residents and their Health 19

1.5 The Fire, its Management and Evacuation 19

1.6 Source and Cause of the Fire 26

1.6.1 Source and Cause of the Fire 26

1.6.2 Potential Involvement of a Resident 28

1.6.3 Lead-up to the Fire and Later Events 28

1.6.4 Conclusion as to the Cause of the Fire 31

PART 2 KNOWLEDGE OF RISK AND SYSTEM DEFICIENCIES 33

2.1 Previous Fires and False Alarms at KRS and Willsmere 34

2.2 MFB Reports, Consultants' Surveys, Inquests and Departmental Directives 37

2.2.1 Introduction 37

2.2.2 MFB Reports 37

2.2.3 Consultants' Surveys and Their Use 40

(1) Introduction 40

(2) Treasury's 'Lumley – Risk Management Survey' 41

(3) BSA's 'Dibben' Report 44

(4) Responses to the 'Dibben' Report 49

(5) Umow Lai & Associates Pty Ltd 53

(6) Scope of the 1994 'Audit': The Role of ULA and SSL 56

(7) The Fabric Survey & Building Utilisation Study 63
2.2.4 Coroners' Inquests 65
(1) Introduction 65
(2) The 1968 Willsmere Fire 66
(3) Recent Inquests 69
(4) Responses to Inquest Recommendations 78
2.2.5 Community Visitors' Reports and the Parents' Association 80
2.2.6 Government Directives and Advice 81
(1) Building Approvals and Government Directives 81
(2) Smoke Detectors 81
2.2.7 Conclusion: A Comparison between Risk and Likelihood 82
PART 3 MANAGEMENT OF RISK AND SYSTEM DEFICIENCIES 85
3.1 KRS's Fire Safety Systems: A Local Management Perspective 85
Historical Overview of KRS Management Response 85
3.2 Upgrade Management 90
3.2.1 Role of the Project Control Group and the Principal Consultant (ULA) 90
3.2.2 Contract to Upgrade the Fire System and Wormald's Role 90
3.2.3 Progress following the ULA Audit 92
3.3 Funding Delays in Addressing Fire Safety at KRS 92
3.3.1 Introduction 92
3.3.2 Attempts and Successes 94
3.4 Delay related to Asbestos Removal 100
3.5 Force of Argument on Delay 102
3.6 Maintenance of Fire Alarm Systems at KRS and Building 37 103
3.6.1 Introduction: Contract 103
3.6.2 Australian Standards and Compliance with Specifications 104
3.6.3 Maintenance and 'Audit' 110
3.6.4 Conclusion: Maintenance 119
3.7 Abandonment of the 'Fire Safety Committee' 120
3.8 Fire Drills and Evacuation Procedures 125
3.8.1 History and System 125
3.8.2 Deficiencies 126

3.9 Management of Fire-lighting Risk by DHS 128
3.9.1 Paul and the Management of 'Fire-lighting Behaviour' or 'Risk' 128
3.9.2 Coronial and Departmental Warnings on Fire-lighting Behaviour or Risk 141
3.9.3 Conclusion on the Management of Fire Risk Behaviour by DHS 146
3.10 Smoking Policy and its Effect on Fire Risk 147
3.10.1 Policy 147
3.10.2 Availability of Cigarette Lighters and Matches: A Risk Assessment 149
3.10.3 Childproof Cigarette Lighters 149
3.10.4 Conclusion 149
3.11 Use of Fire Resistant Furniture, Bedding and Materials 149
3.12 Automatic Door Locking/Release Systems 150
3.13 Staffing Ratios for Fire Emergency 152
3.13.1 Introduction 152
3.13.2 After Hours 153
3.13.3 Expert Opinion on Night Staffing Levels for Fire Emergency 155
3.13.4 Conclusion 160
3.14 Failure to Introduce 'Interim' Solutions 161
3.14.1 Introduction: Relevance 161
3.14.2 Early Moves towards a Local Warning Device: Wormald's Quotation 163
3.14.3 ULA and SSL's Advice: A 'Hardware Solution' 165
(1) Scope of the 1994 Proposals for an 'Interim' Solution 165
(2) Types of Interim Hardware Solutions Available 169
(3) Conclusion 175
3.14.4 Management's Role: A Risk Management Approach 175
3.14.5 Conclusion 177
PART 4 SURVIVAL AND THE DETECTION SYSTEM ON 8 APRIL 1996 179
4.1 State of the Fire Alarm System on 8 April 1996 179
4.1.1 Introduction: Fire Safety Systems at the Time of the Fire 179
4.1.2 Clues to the State of the System: Experts' Views and Consultants' Surveys 181
(1) Experts' Views on the Fire 181
(2) Consultants' Surveys 184
4.1.3 The Various Theories on the State of the System 185

(1) Insipient or Rapid Fire Growth? 185
(2) Summary of Theories 186
4.1.4 Maintenance: Effect on the Existing System 186
(1) Experts' Views 186
(2) Counsels' Submissions 187
4.1.5 Fire Alert System Installation: Potential to Affect Existing Alarms 189
(1) Interference during Installation and the 'Cut in' Theory 189
(2) Removal of Detectors by Wormald 190
(3) The 'Bypass' Theory 192
(4) The 'Reverse Polarity' Theory 194
(5) The 'End of Line Resistor' Theory 194
4.1.6 Sprinkler System Installation: Potential to Affect Existing Alarms 194
4.1.7 Airconditioner Installation: Potential to Affect Existing Alarms 195
4.1.8 Damage to Detectors and Integrity of Fire Safety Systems 195
(1) Relevance of Damage to Detectors 195
(2) Frequency of Resident or Unidentified Damage to Alarms at KRS 196
(3) Painting 197
(4) Conclusion 198
4.1.9 General Integrity of the Fire Alarm System 198
(1) Wiring 198
(2) Positioning 202
(3) Number of Detectors on Circuits 204
(4) Conclusion 204
4.1.10 Fire Alarm Plans for Units 30/31 and the 'January Plan' 204
(1) Relevance of the 'January Plan' to Indicate the State of the Alarms 204
(2) Evidence on the 'January Plan' 205
(3) Conclusion on the 'January Plan' 210
4.1.11 Evidence of the Maintenance Contractor on the State of the System 211
4.1.12 Lack of Plans on Site: Difficulty for Safety and Investigation 222
4.1.13 Wormald's Alleged Involvement in the Investigation 223
4.1.14 Conclusion on the State of the System 225
4.2 Potential for Survival under the Existing Fire Alarm System 226

4.2.1 Fire Development Sequence 226

4.2.2 Evacuation on the Night 228

4.2.3 Potential to Survive with a Functioning Smoke Detector 230

PART 5 BUILDING LAW AND THE FIRE 232

5.1 Fire Safety: Building Classification, Use and Regulation 232

5.1.1 Background 232

5.1.2 Legal and Historical Overview 232

5.1.3 Experts' Views: A Problem of Classification 235

5.1.4 Experts' Views: Fire Safety and Building Requirements at KRS 236

5.2 Alterations to Building 37 (Unit 31): Effect on Fire Safety 239

5.2.1 Construction of Building 37 and Unit 31 239

5.2.2 Alterations and Certification as Affecting Fire Safety in Building 37 240

(1) Introduction 240

(2) KRS's Approach to Renovations and Risk 241

(3) Lost Opportunity to Re-engineer the System in Building 37 252

(4) Role of the Building Surveyor 252

5.2.3 The Building Surveyor and KRS Management 262

PART 6 ROLES OF CONSULTANTS, CONTRACTORS AND MANAGEMENT IN CONTEXT 263

6.1 Introduction 263

6.2 The Consultants and Management 264

6.2.1 ULA 264

6.2.2 SSL 266

6.3 The Contractors and Management 267

6.3.1 Jonkar 266

6.3.2 Wormald 268

6.3.3 Ashlar 270

6.4 Conclusion: Management Responsibility 272

PART 7 STATE OF VICTORIA'S (DHS) ACKNOWLEDGEMENT OF DEFICIENCIES 275

7.1 Introduction 275

7.2 Fire Detection/Prevention Systems, Training and Evacuation Procedures 276

7.3 Fire-lighting Behaviour, Record Keeping and Staff Training: 9 April 1997 277

PART 8 LEGAL ISSUES AND CONTRIBUTION 281

8.1 Legal Issues 281

8.1.1 Introduction 281

8.1.2 Investigatory Framework: The *Coroners Act* 1985 281

8.1.3 Applicable Legislative and/or Common Law Framework 282

(1) Duty to Residents at KRS 282

(2) Duty to Staff at KRS 282

(3) Nature of Duty to Residents and Staff at KRS 282

8.1.4 Concept of Contribution 283

8.2 Contribution to the Fire and Deaths 286

COMMENTS AND RECOMMENDATIONS 291

PART 9 COMMENTS AND RECOMMENDATIONS 291

9.1 Introduction: The Future 292

9.2 Sprinklers Will Save Lives 294

9.3 Audit Reports: Need to Define and Manage 297

9.3.1 Need for Regular Fire Audits 297

9.3.2 Need to Define 297

9.3.3 An 'Audit Trail' 298

9.3.4 Need to Manage Audit Reports and Recommendations 298

9.4 Maintenance: 'Contracting Out' and the Requirement for 'Audit' 299

9.5 Interim Solutions: An Industry Standard or Code 299

9.6 A System for Fire and Evacuation Procedures 301

9.7 Management: Responsibility to Manage Risk 302

9.8 Fast-track Funding 303

9.9 Building Issues 303

9.10 Fire Safety and 'Congregate Care' 304

9.11 Management of Fire-lighting Behaviour or Risk 306

9.12 Fire and 'Occupational Health & Safety' 307

9.13 Learning from the KRS Fire: Parties' Recommendations 307

9.14 General Issues 308

9.14.1 Future Management of Paul 308

9.14.2 The Investigation and 'Fire Test' 308

9.14.3 Commendations 311

9.15 Conclusion 311

APPENDICES 313

Appendix 1 Summary of Findings, Comments and Recommendations 315

Appendix 2 Plans and Chronology 341

Appendix 3 Recommendations of Parties on Fire Safety 385

Appendix 4 Responses to Recommendations of Parties on Fire Safety 433

Appendix 5 Bibliography 491

Appendix 6 Glossary of Abbreviations 493

Appendix 7 Acknowledgements 495

INTRODUCTION

On the evening of 8 April 1996, a fire occurred in Flat E, Unit 31 of Building 37 at Kew Residential Services (KRS), Kew. Tragically, the fire took the lives of nine intellectually disabled residents. Kew Residential Services is operated by an agency of the Victorian Government, the Department of Human Services, and accommodates approximately 600 intellectually disabled persons. The fire detection and protection system at KRS has been the subject of continued criticism and concern over several decades. During that time a number of governments and their agencies have been responsible for the residents at Kew. The one constant is that such residents should be protected from the devastating effects of fire by the State of Victoria, and that that protection should have been in place to prevent the tragic events of 8 April 1996.

It is during the currency of the present government that the most substantial commitment to upgrade fire system hardware was implemented and, sadly ironic, that the completion of the sprinkler system, which predictably would have saved the lives lost, was delayed by the discovery of asbestos in the roof of Building 37. The commitment and move towards implementation of the fire safety system upgrade is to the credit of the current government and its agent, the Department of Human Services. It is also notable that the Department of Human Services has now undertaken a major fire risk management strategy, which is supported by substantial government funding, with a view to a positive long-term outcome across all of its operations. For that approach credit is both appropriate and due.

Throughout the inquest, it became apparent that the fire was the culmination of a massive systems failure involving unsatisfactory fire protection hardware, inadequate maintenance and very real weaknesses in emergency staff training, evacuation procedures, communication and safety protocols. Nevertheless, while the inquest findings direct criticism for the management of fire safety at KRS during the upgrade, a degree of balance must be exercised. It is essential when considering the real weaknesses in systems, hardware and training to be mindful of viewing the issues, not in light of today's standards and practices, but with an eye to the knowledge that applied before the fire. Further, in the process of examining the extent of the systemic deficiencies surrounding the fire, the roles of the individuals involved must be viewed with considerable caution in order to recognise the implicit restrictions on their position in the context of the respective bureaucratic or agency structures, culture and budgetary constraints.

This inquest has involved 81 sitting days, with evidence comprising over 7000 pages of transcript and 300 exhibits. On one view, the issues involved may have appeared to an outside observer to involve a straightforward inquiry. In understanding the complexity of the issues involved, it should be noted that the police brief, itself a commendably thorough investigation into the circumstances of the night of the fire, ultimately occupied only a proportion of the scope of the inquest. In running, the emphasis moved from a limited investigation into how the fire started to a more probative investigation concerning the adequacy of the range of fire safety systems for the intellectually disabled residents at KRS.

Originally, the inquest was expected to take two months and involve perhaps three parties. This was the position at the early court mention days. As the focus moved to the various organisations and agencies associated with the provision of advice, systems and hardware maintenance to KRS, the number of parties, detail and complexity multiplied accordingly.

In view of the large amount of material and numerous additional witnesses that came to light during running, the hearing took longer than anticipated. Indeed there was potential for the inquest to take many more months than it ultimately did. In the end it was considered appropriate to strike a balance between the degree of fine detail sought and a practical conclusion of the investigation. Accordingly, it was felt necessary to bring the inquest to an end because, otherwise, it would no longer have served its purpose.

In the final analysis, it is to be hoped that the scope and detail developed will be reflected in the learning derived from this process. While the court is legally limited as to the extent of the

recommendations that can be made following an inquest on a particular fire, the systemic problems identified have resulted in many of the parties taking a broader approach. Certainly, there has been an unprecedented amount of work put towards learning from the identified problems and what can be done in the future to reduce the incidence of fire in our community. Many of the parties have adopted and developed this broader approach during the running of the inquest. This can be seen in the well-developed and extensive preventive recommendations of the State of Victoria (and the Department of Human Services), the Building Services Agency (Department of Infrastructure), the Metropolitan Fire Brigade (Department of Justice), Umow Lai & Associates, Wormald Fire Systems, the Kew Cottages & St Nicholas Parents' Association, the Health and Community Services Union, the Office of the Public Advocate and Villamanta Legal Service. Our community, both in the public and private sector, must benefit from this invaluable work.

It is noted that the positive input of the various parties, through their instructing solicitors and counsel, has been extremely helpful throughout the inquest process. The emphasis placed in the running of this inquest on a positive learning experience has been greatly enhanced by the ready cooperation and assistance of all parties involved.

The court has the benefit of counsels' substantial written submissions and replies, along with much material provided during the inquest. The submissions and replies themselves total about 2000 pages. All of that information has been taken into account in completing the findings. It should be noted, for very obvious and practical reasons, that it has not been possible either to mention or refer in detail to every point or theme made in evidence or submissions. The fact that a particular point is not developed should not be taken to indicate that the court is necessarily in agreement or otherwise. Material has also been provided by the Grant and Anderson families, and their input is appreciated. The Grants lost their son Thomas in the fire. The Andersons' son Bruce was seriously injured.

The dignified daily attendance of a substantial number of the members of the Kew Cottages & St Nicholas Parents' Association has been noted. Their regular attendance and positive approach underscores the importance of learning from this tragic incident.

ABOUT THIS DOCUMENT

The Findings, Comments and Recommendations are divided into nine parts, each of which is introduced by a brief summary of the information contained therein. The Findings are covered in Parts 1 to 8 while Part 9 contains the Comments and Recommendations. To assist in an understanding of the materials, there is a summary of each Part of the Findings, Comments and Recommendations to be found in Appendix 1 to the Findings. A chronology, prepared by the MFB, is contained in Appendix 2 to the Inquest Findings. This provides additional factual information in summary form to assist with an understanding of a complex history and set of facts.

The Appendices provide plans and diagrams to assist the reader in an understanding of the state of the alarm system on the night of the fire. Also provided is the detail of the recommendations on counter-measures made by several of the parties to the inquest. Finally, the Appendices contain the general acknowledgements to the individuals and agencies involved in the inquest.

Graeme Johnstone
State Coroner
17 October 1997

Assisted by Messrs Graeme Hicks and Michael Hennessy (instructed by Ms. Vanessa Ash of the Office of the Director of Public Prosecutions)

CONCLUSION TO FINDINGS, COMMENTS AND RECOMMENDATIONS

1. The State of Victoria owed a duty of care to the staff and the nine intellectually disabled residents at Kew Residential Services.

2. For ten years (since 1986), the State of Victoria had been given warning after warning by consultants, experts, personnel and different government instrumentalities as to the inadequacy of the fire safety system at Kew Residential Services.

3. These warnings had been given to the State of Victoria over the period of several governments and departmental agencies having responsibilities for fire safety at Kew Residential Services.

4. The present government and the Department of Human Services had made substantial efforts to upgrade significantly the fire safety systems at Kew Residential Services.

5. However, the fact remains that ten years is far too long for the State of Victoria to have got its house in order, particularly when considering the life and safety of the persons to which it owed a duty of care.

6. The State of Victoria has contributed to the fire and deaths of the nine residents because, despite all the warnings it had received over the decade from 1986, no proper fire safety system was in place at the time of the fire.

7. This is not the only way in which the State of Victoria has contributed to the deaths. These other ways are detailed in the Findings.

8. The role of various consultants and contractors was comprehensively investigated during the inquest, and a number of shortcomings, areas of criticism and scope for improvement have been identified; however, on the recognised legal standard, those parties have not contributed to the deaths.

9. Nonetheless, it is encouraging that the State of Victoria was undertaking substantial efforts towards a proper fire safety upgrade at the time of the fire. In addition, during the currency of the inquest, the State has made several positive moves towards improving fire safety. The commitment of $75.5 million to *'continue the program of fire safety audits and works'* in Department of Human Services facilities is a particularly positive step. The extent of the positive work towards improving fire safety along with the implementation of the many recommendations will, no doubt, significantly reduce the chance of such an event recurring.

10. Throughout the inquest, the importance of learning from the fire so that the same errors will not occur again has been stressed. The positive lessons learnt from the investigation of the fire will have consequences for other governmental and private institutions that look after intellectually or otherwise disabled persons.

11. The Kew Residential Services fire remains a tragedy for the State of Victoria and, in particular, for the victims and their families.

Graeme Johnstone
State Coroner
17 October 1997

Assisted by Messrs Graeme Hicks and Michael Hennessy (instructed by Ms. Vanessa Ash of the Office of the Director of Public Prosecutions)

FIRE AT KEW RESIDENTIAL SERVICES ON 8 APRIL 1996

THE FINDINGS

PARTS 1–8

PART 1 THE FIRE, ITS AFTERMATH AND CAUSE

This Part presents the history of Kew Residential Services (KRS), and deals with the fire in Flat E, Unit 31, Building 37 in early April 1996 and the resultant deaths of nine intellectually disabled residents. It covers the lead-up to the fire, the attendance of the Metropolitan Fire Brigade and the evacuation of residents by staff and firefighters. Expert evidence on the source and cause of the fire is considered. It is found that the sole surviving intellectually disabled resident in the flat lit the fire with a cigarette lighter.

The difficulties with the evacuation experienced by both staff and firefighters are also discussed.

Further, the likely time of commencement of the fire is considered. This issue is important in relation to the determination of both the state of the alarm system on the night and the probability of survival with a properly maintained alarm system.

The finding that a resident caused the fire eventually is to result in a finding of contribution by the State of Victoria by its agent – the Department of Human Services (DHS) – for failing to manage an issue of probable fire-lighting risk. That issue will be considered in detail in Part 3.

1.1 THE DEATHS

The deaths of Alan Negri, Joseph Richmond, Adrian Edmunds, Thomas Patrick Grant, Shayne Newman, Bruce Mark Haw, Stanley Mathews, Peter Arthur Bernard Otis and Ronald Aldridge all occurred in the evening of Monday, 8 April 1996 at Kew Residential Services, Princes Street, Kew from smoke inhalation and burns.

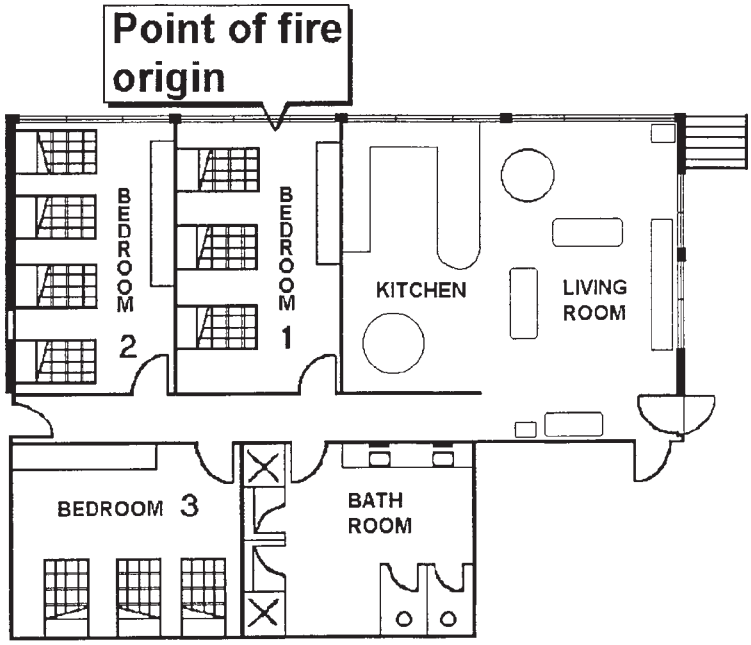
1.2 SUMMARY OF THE CIRCUMSTANCES OF THE FIRE

At approximately 10.49 p.m. on 8 April 1996, a fire commenced in bedroom 1, Flat E, Unit 31, Building 37, 6 Lower Drive, KRS. Building 37 was made up of two units – 30 and 31. Unit 30 housed Flats A and B. Unit 31 comprised Flats C, D and E. The facilities at KRS are operated by DHS.

The alarm of the fire rang at the Metropolitan Fire Brigade (MFB) Communication Centre at about 10.56 p.m. The first MFB pumper arrived at KRS approximately five minutes later. By the time the pumper had arrived, the fire had broken through the roof above Flat E. It had also begun to spread through the roof space to the adjoining Unit 30 when it was checked by a number of firefighters. The fire had rapidly developed to engulf all of Flat E, Unit 31, and parts of Flats B, C and D were also damaged. The remainder of the building received some smoke damage. After the alarm was raised, a number of staff at KRS began a difficult and traumatic evacuation of the surviving residents. They were assisted by a number of firefighters who arrived within minutes.

The fire was started with a cigarette lighter by the sole surviving resident of Flat E. He did not understand the consequences of his actions.

A sprinkler system was in the process of being installed to Units 30/31. However, at the time of the fire, it was not operational. A new addressable alarm system was also about to be installed.



Plan of Building 37, 6 Lower Drive, KRS

1.3 HISTORY OF KRS, ITS ENVIRONS AND THE NATURE OF ITS RESIDENTS AND STAFF

A descriptive history of KRS and the building in which the fire occurred was provided in the MFB Report:

> *Kew Cottages was built in 1887 in the grounds of the Willsmere Hospital. The cottages originally consisted of three cottages and a school with accommodation being provided for 20 children. In 1891, two additional cottages were built to deal with overcrowding.*
>
> *The additions at Kew Cottages continued into the 1900s with the construction of Building 37 ... being completed as part of a 5 building addition to the complex.*
>
> *Building 37, located at 6 Lower Drive Kew Cottages was originally built in 1960 to house 40 beds in a nursing home style of accommodation.*
>
> *The building had undergone a number of structural modifications over the years, dividing the structure into two distinct units known as Unit 30 (comprising the western half of Building 37) and Unit 31 (comprising the eastern half of Building 37).*
>
> *The most recent modification occurred in June 1993. The purpose of this modification was to allow for the accommodation of up to 64 residents in villa type accommodation. At the time of the fire, Building 37 occupied a total of 46 residents and 2 carers.*[1]

The institution formerly known as 'Kew Cottages' is situated on about 40 hectares of parkland in the Melbourne suburb of Kew, and contains 28 residential units. KRS provides accommodation for about 600 residents ranging in age from 21 to 68 years. It is a residential facility, not a hospital,

1 MFB Report, p. 1.

designed as far as practicable to provide a home-like atmosphere. The residents are encouraged to take part in hobbies and may be permitted to consume alcohol or smoke cigarettes. The smoking policy provides for an informed choice by a resident. However, smoking is not permitted in accommodation units.

The police summary as to the nature of the residents residing at KRS reads:

> *Most of the clients living at Kew ... have lived in institutions all of their life. The extent and type of their disability varies and therefore they have varying degrees of support needs. It is estimated that two hundred and seventy three individuals are considered to have severe and or multiple disabilities, which require high levels of support. A significant number of individuals at Kew ... present with challenging behaviours, which also require high levels of supervision. The remaining clients, range in skill levels from those requiring a medium level of supervision/support, to a few requiring a low level of support.*[2]

As indicated, the facility at KRS is currently run by DHS. The departmental names of the predecessors of DHS include the Health Department and the Department of Community Services.

With the commencement of the *Intellectually Disabled Persons' Services Act 1986*, principles were enunciated whereby the services to be given to people with intellectual disability were to emphasise their rights to lead as normal a life as possible.[3] From the development of the State Plan for Intellectual Disability Services in 1989, a commitment to deinstitutionalisation led to a number of residents being moved from KRS into the community. At KRS some units were divided into bedrooms *'which aimed to improve living conditions, bringing them closer to normal patterns of the community'*[4] and enhancing the residents' privacy. Day and semester programs were introduced. Services for residents in day program options have substantially increased over the last few years:

> *through an increase in day program funding both through the purchase of specific services to meet. client needs and through the ongoing development of Disability Day Programs.*[5]

It has also been said that *'[t]he past 10 years have seen significant change and improvements at KRS to provide a more homely living environment and a better quality of life'*.[6]

The 1994 'Kew Vision' was aimed at improving residents' quality of life and living conditions. Under this program gardens and backyards were established for some units. The number of residents in locked accommodation was also substantially reduced. The number of residents on chemical restraint was reduced to a low of nine per cent in 1996.

Originally, the buildings at Kew provided accommodation in dormitory-style for up to 40 residents. Over recent years, in line with the direction towards the provision of a home-like atmosphere, there has been a move towards altering the buildings to accommodate self-contained flats. Those flats are linked, and each contains a small number of bedrooms with kitchen facilities and a bathroom. In 1994 a number of units were renovated to provide flat-style accommodation. In 1995, *'Unit 31 and Unit 5 commenced renovations to move to the flat model to improve living conditions, increase client choices and decision making, promote everyday living skills development within the client group and create a homely atmosphere'*.[7] Unfortunately, as this case demonstrates, without well-

2 Exhibit 4 – Coroner's Brief – Police Arson Squad, p. 3.

3 See generally State of Victoria Submission in Reply, pp. 1-6; Public Advocate's Submission, pp. 166-174.

4 State of Victoria Submission in Reply, p. 1.

5 State of Victoria Submission in Reply, p. 6.

6 State of Victoria Submission in Reply, p. 6.

7 State of Victoria Submission in Reply, p. 4.

maintained (and audited) fire safety hardware systems and sprinklers combined with properly trained staff, the division of large accommodation buildings into a number of flats presents problems for the safety of both residents and staff.[8]

A range of staff at KRS provide a variety of support services for clients. Each unit is managed by a Mental Retardation Nurse (MRN level 3) with assistance from MRN (level 2). Residents are cared for by Intellectual Disability Service Officers (IDSOs) or DHS workers (HSWs). These carers provide personal assistance and support for residents. They also assist in encouraging residents to develop more independent skills.

1.4 RESIDENTS AND STAFF AT 'BUILDING 37' DURING THE FIRE

1.4.1 THE DECEASED

All of the residents of Units 30 and 31 at KRS were intellectually disabled, and all of them (including survivors) had lived at Kew for a number of years. All of the deceased residents lived in Flat E, unit 31. Only one of the residents of Flat E – Paul – survived.

The profiles of the residents were such that they presented significant emergency management difficulties for staff and fire brigade officers. A report provided on Staffing Levels by Warrington Fire Research examined the resident profiles of the 46 individuals who resided in Units 30/31. Unit 30 housed 21 residents – Flat A with nine and Flat B with 12. Unit 31 housed six residents in Flat C, nine in Flat D and ten in E. On the night of the fire, there were 45 persons in residence, with one resident not staying in the complex.

In reaching a conclusion that '*staff would have to assist in the evacuation of the clients and would also be needed to prevent re-entry to the building'*, Warrington examined and tabled a number of topics in the report.[9] The topics included: mobility; response to instruction; resistance to evacuation; hearing impairments; visual impairment; medication; psychiatric disorder and intellectual disability. Within each topic, there were significant management problems for staff.

None of the deceased demonstrated any particular interest in fire nor did they smoke. The deceased residents' histories are as follows:

---

8 See the Public Advocate's Submission, p. 36 et seq.; see also pp. 37-38:

The recent incidence of death by fire in Australian institutions of residence suggests that the statistical risk of death by fire in a congregate setting is higher than in any other type of accommodation. In the 6 year period, 1 July 1989 to 30 June 1995, a total of 172 people died in Victoria by fire or gassing. Of these, 125 died in their own home or residence, including tents, caravans, trailers etc. A total of 20 people died in residential institutions, including hospitals, special accommodation facilities, aged hostels and residential services for people with a disability, such as Kew Residential Services. Significantly, of all people in Victoria who died by fire or gassing in their dwellings, 16% died in congregate settings.

In order for these figures to be meaningful in the context of these submissions, the Public Advocate sought to compare these figures with the total number of people living in domestic dwellings against the number of people living in residential institutions, defined as establishments by the Australian Bureau of Statistics. Taking the year 1993, the ABS estimated that 16,169,600 people aged over 5 years lived in households, while 166,500 lived in residential institutions. This translates to a figure of approximately 1.03% of all people aged over 5 being estimated to live in congregate settings. As a consequence, it appears that people living in congregate settings such as Kew Residential Services currently have a significantly higher probability of dying by fire or gassing (by a factor of 15) than people living in domestic dwellings, including community residential units.

9 See generally Exhibit 283, pp. 3-5.

(1) Mr Alan Negri,[10] who was aged 61, was born at Woods Point on 13 January 1935. He had four siblings, and had lived with his parents until his father died. In his late twenties, he was admitted to Caloola at Sunbury where he lived until Caloola's closure in 1992. Mr Negri was then transferred to KRS.

(2) Mr Joseph Richmond,[11] who was aged 35, was born in Melbourne on 7 February 1961. He was diagnosed as suffering from Downs Syndrome and resided at Allambie Centre from September 1965 until his admission to Kew Cottages on 30 December 1969. He had three brothers and one sister.

(3) Mr Adrian Edmunds,[12] who was aged 39, was born at Ivanhoe on 21 July 1956. He had two brothers. Shortly after his birth, Mr Edmunds was diagnosed with Downs Syndrome and was admitted to Kew Cottages.

(4) Mr Thomas Patrick Grant,[13] who was aged 36, was born at Richmond on 29 June 1959. He had four siblings. At about the age of four, he was diagnosed as being mentally retarded. He resided with his parents until the age of ten when he was admitted to Kew Cottages.

(5) Mr Shayne Newman,[14] who was aged 38, was born in Melbourne on 8 September 1957. He had one older brother (now deceased) and two sisters. He was diagnosed with cerebral palsy, and continued to live at home and attend at the Yooralla School. He was admitted to Kew Cottages in 1972.

(6) Mr Bruce Mark Haw,[15] who was aged 39, was born in Melbourne on 23 November 1956. At 18 months he was diagnosed as having a mental retardation problem and admitted to Kew Cottages in 1961. In 1985 his mental retardation problem was discovered to be Fragile X Syndrome. Mr Haw had three sisters, including a twin who also suffered from Fragile X Syndrome.

(7) Mr Stanley Mathews,[16] who was aged 42, was born in Melbourne on 1 October 1959. He was diagnosed with cerebral palsy at 10 months, and in 1959, was admitted to Kew Cottages. He had four brothers and two sisters. It is understood that Mr Mathews was also deaf.

(8) Mr Peter Arthur Bernard Otis,[17] who was aged 37, was born in Melbourne on 17 May 1958. After being diagnosed as autistic at the age of four, he was placed on the waiting list for Kew Cottages by his parents. He was admitted to Kew on 27 May 1964, and lived there until his death. He had five brothers and four sisters.

(9) Mr Ronald Aldridge,[18] who was aged 31, was born on 23 February 1965. His place of birth is not known. At the time of his birth, he had three sisters and a brother. Mr Aldridge's mother, Mrs. Grace Jackson, is now deceased, and none of his siblings was aware of his existence until after his death.

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10 Coroner's case file no. 1018/96.

11 Coroner's case file no. 1019/96.

12 Coroner's case file no. 1020/96.

13 Coroner's case file no. 1021/96.

14 Coroner's case file no. 1022/96.

15 Coroner's case file no. 1023/96.

16 Coroner's case file no. 1024/96.

17 Coroner's case file no. 1025/96.

18 Coroner's case file no. 1026/96

1.4.2 THE SURVIVORS

Two residents (of Flat C) and one staff member were injured during the fire. All received hospital treatment. The two residents, Messrs Bruce Anderson and Stewart Heaton, were seriously injured. The member of staff, Mr Chea Earpeng, who assisted in the rescue, suffered minor smoke inhalation.

Paul, a resident of Flat E, apparently exited the building under his own direction. He was not injured, and his clothing showed no sign of heat or smoke damage. As already indicated, Paul was the only survivor of the residents of Flat E.

The 35 residents who survived were evacuated by staff and Fire Brigade Officers.

1.4.3 USE OF THERAPEUTIC DRUGS FOR MANAGEMENT OF RESIDENTS AND THEIR HEALTH

The toxicological reports for some of the deceased residents indicated the presence of drugs at therapeutic levels. There was no material to suggest that the various levels of therapeutic drugs would have significantly affected their mobility during the course of the fire.

Accordingly, this is not considered to be an issue for the inquiry.

1.5 THE FIRE, ITS MANAGEMENT AND EVACUATION

The automatic fire alarm rang at the MFB Communication Centre at 22.56.12 hours. A number of appliances were dispatched to KRS. The first pumper arrived at 23.01.49 hours, some five minutes 37 seconds later, and confirmed an extensive fire. At 22.57.35 hours, the MFB Communication Centre received a telephone call from KRS (Mr Craig Free) confirming the operation of an alarm. The MFB operator responded, *'[R]ight do you have a fire?'* KRS replied *'No.'* The conversation continued:

> *MFB operator: ... [C]an you tell whereabouts its operating?*
>
> *Kew: Yep, Unit 30/31.*
>
> *MFB operator: Unit 30/31 operating?*
>
> *Kew: Yep.*[19]

Mr Free explained that he was surprised by the MFB operator's question. As he had not received confirmation on the internal (KRS) emergency telephone, his immediate response was in the negative.[20] He was in the Administration Building with Mr Barry Wales.

A short time earlier, immediately after the alarm started ringing on circuit 39, Wales telephoned Units 30/31 to warn the staff of the alarm. He spoke to Mr Chea Earpeng who was on duty with Mr Bartel Frlan. Mr Chea was responsible for caring for the residents in Unit 31 and Frlan for those in Unit 30. Wales received a return telephone call from Frlan checking on whether there was in fact a fire. Wales then commenced to telephone staff in other units for help.

Clearly, a fire alert system whereby the administration staff initially denied the MFB report of a fire, and then had to inform the carers in the very building where the fire was, is deficient. This is

19 MFB Report, p. 5.

20 Coroner's Brief – Police Arson Squad, p. 122.

particularly so in light of subsequent evidence that indicated that the fire had been burning at this stage for some minutes.

Mr Chea was the first person on the scene of the fire, and by this stage it was well alight. He was in the kitchen at the front of the building when telephoned by Wales. This call was made about two minutes after the alarm. The instructions were to evacuate. After alerting Frlan, Chea recalled:

> *... At this stage everything in the building was quiet and I couldn't see or smell any smoke.*
>
> *I ran through the building to check Flats C and D banging the wall and doors as I went and then went to check Flat E. As I turned into the kitchen adjoining flat E, I saw smoke suddenly billowing from the ceiling above the corridor which the bedrooms to this flat lead off. This was illuminated by the toilet light behind me. It is normal practice to leave the toilet lights on over night so that the clients can get up and go to the toilet. The light behind me was the C Flat toilet light. I can't remember if the E Flat toilet light was on or not. All I could see was the smoke coming out of the ceiling. I couldn't see any flames or feel any heat at this stage. I attempted to turn the hallway light to the Flat E bedrooms on but it wouldn't work. The smoke filled the room very quickly so I started to crawl under the smoke towards the bedrooms but was driven back by the smoke because I couldn't breathe. While doing this I was screaming continually trying to alert the guys. I went back into the small corridor which leads into the E Flat kitchen to get my breath and then back into the smoke. <u>This time I could see flames coming from the ceiling in the place that I originally saw the smoke come from.</u> I couldn't see anything else because of the smoke and I didn't see anybody come out of the E Flat bedrooms. I can't remember if any of the bedroom doors were shut. ... This time I was forced back by smoke and heat I gathered my breath in the corridor once again and tried to crawl back into Flat E under the layer of smoke, but I didn't get far before being forced back into the corridor. The fire and smoke had spread so quickly that I couldn't get back into Flat E.*[21]

After being alerted by Mr Chea, Frlan telephoned Wales to confirm that it was not a drill. He then set about rescuing the residents in his Unit (30).

A number of staff telephoned by MrWales immediately left their units on foot to assist in the evacuation.

The first to approach the scene from various directions observed a well-developed fire. One of the first, Mr Free was '*half way between the unit and the administration block*' when he saw '*smoke coming from the unit. There weren't any flames but there was quite a bit of smoke and it was coming from the middle of the unit towards the back'*.[22] The flames were not visible from the southern approach. Some staff approaching the area shortly after Free stated that the fire had penetrated the roof.

An example of staff observations is from the statement of Ms. Catherine Backhouse, Intellectual Disability Services Officer, who was on duty in Unit 21 on the night of the fire. Backhouse was one of the first members of staff to reach the scene of the fire. She was in Unit 21 when telephoned by Wales. By the time she left the unit she observed the flames *'coming out of the roof in the middle of the building'*.[23] This view is also confirmed by Ms. Raelene Schwab who '*... saw bright orange/ yellow flames quite high in the sky'*[24] *'... 20 metres in the sky'*.[25]

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21 Coroner's Brief – Police Arson Squad, statement of Chea Earpeng (emphasis added).

22 Coroner's Brief – Police Arson Squad, p. 122.

23 Coroner's Brief – Police Arson Squad, p. 127.

24 Transcript, p. 1651.

25 Transcript, p. 1683. This view is confirmed by a number of other witnessess who observed flames at varying points and times: Mr Wolfgang Ansorge: Coroner's Brief – Police Arson Squad, p. 130; Ms. Balbir Sobia: Coroner's Brief – Police Arson Squad, p. 134; Ms. Agnes Acquah: Coroner's Brief – Police Arson Squad, p. 132; Mr Muharen Sen, who saw '*... a glow ...*' ' *... you could just hear the crackling sound ...*' ' *... there must have been flames, you know. It was on fire ...*': Transcript, pp. 2063-2064; Ms. Kristina Sango, who ' *... just saw smoke*.': Transcript, p. 2270.

Mr Christopher Crofts of Wormald Security, who was near the Administration building, heard the alarm and went into the office. While looking at the alarm panel, he observed a light at point 27 (on circuit 39), and while looking at this panel, an additional light at 28 (circuit 40) lit up. He told staff and then exited the building. Crofts said that:

> *by the time I got to my car the Fire Brigade were at the entrance to the cottages. I waited for them to come and directed them to follow me. I knew exactly where to go because I had asked the staff member in administration. The weather at this time was raining and very wet. I could not see anything until I drove down Lower Drive and when I was about at the gardeners area I saw flames heading about 23-30 feet out of the roof unit 31.*[26]

It appears that by the time the first MFB pumper arrived, the flames had broken through the roof of Unit 31. Mr Crofts' evidence puts the time the flames had broken through at about five minutes after the first alarm (the first pumper arrived five minutes 37 seconds after alarm). Conversely, circuit 40 operated just under five minutes after circuit 39. Firefighters who arrived at KRS between 23.01.49 hours and 23.04.59 hours also observed a well-developed fire.

The MFB has a system of grading fires into categories, which results in an upgrade of the number of appliances directed to fight a fire. Such an upgrade occurred at the fire scene from a first response alarm to a fifth alarm between 22.56.12 hours and 23.22.08 hours. Pumper 10 was first dispatched from Richmond, followed by Pumper 18 from Hawthorn, Pumper 19 from Balwyn and Teleboom 10. Initially, nine firefighters attended within minutes of the alarm to the Communication Centre. A number of units from other suburban stations attended shortly after the initial responses along with senior fire officers. Once the alarm was raised, the response of the MFB was rapid.

Additional observations about the progress of the fire and evacuation were made by firefighters who arrived at the scene. A critical examination of the facts establish that the nine residents had probably died by the time the fire alarm was raised and before chance of rescue by KRS staff or fire brigade officers.

The MFB arrived to find a well-involved fire in Flat E. Five KRS staff made observations of Unit 30/31 within the first five minutes of the alarm of fire. Their information describes a fire that was well alight. This is suggestive of a late alarm being given by the system in Flat E.

The first fire officers who entering the building from the main southern entrance observed a smoke-logged room (Flat C). The smoke was down to two to three feet above the floor.[27] Firefighters Giacomi and Smith, wearing breathing apparatus, entered Flat C in visibility so poor that *'you couldn't see your hand in front of your face'*.[28] In a bedroom beside the corridor connecting Flats C and E, flames were observed breaking through the skylight in that bedroom. Following unsuccessful attempts to douse the flames, they continued down a smoke-logged corridor to the door to Flat E (door 7) where they could see an orange glow. The door was warm and partly fire damaged. They tried to open the door but were ordered to withdraw by Senior Station Officer Paul Henderson because he feared that the roof would collapse.[29]

A short while later Senior Fire Fighter Peter Calder made his way into Flat C and up the same corridor. He was alone. Calder knocked door 7 down and attempted to extinguish the fire:

> *I saw a fire at the end of this hallway which appeared to be burning the top section of this door, I could tell that the door was definitely shut. I immediately put water onto the burning section of the door and then proceeded to the door. The door was pretty badly*

26 Coroner's Brief – Police Arson Squad, p. 143.

27 Transcript, p. 309.

28 Transcript, p. 311.

29 Transcript, p. 317.

damaged so I kicked the door in. Looking at the map of the layout, the door in question leads into flat E. You could tell that there was a major fire behind the door in that room, because it was burning fiercely. I then directed a main stream of water in the room. I stayed in the doorway but it was very hot and I was in this area for about four or so minutes.

At this stage someone backed me up and then I was told to pull back. I was told to pull back because the roof was going to collapse. At this stage the roof was still intact and the area around us was totally involved. There was a fierce fire burning in this room. The room in question is the kitchen/living area of Flat E.[30]

Mr Calder described his attack on the fire in his evidence at the inquest. His evidence is a telling example of the risk fire officers take to protect the public:

Question: If I can take you over the page on your police statement. "The door was pretty badly damaged, so I kicked the door in." What are you referring to there; what door is that?

Answer: When I went down the hallway, because that was well alight, I turned on the hose line and extinguished most of the fire, and then kicked the door – door in.

Question: And you say there that there was a major fire and it was burning fiercely. And you refer in the next paragraph to it being totally involved. Is that the position?

Answer: Yes, I entered to – went to door 7 and stood in the doorway, and that whole area of what I could see was totally involved.

Question: If I can take you to the second page of your interview with Inspector – well, the third page of your interview with Inspector Martin – you say, halfway down that, you couldn't tell where the fire was burning more. You say, "No, it was rolling across the ceiling, in all directions. It seemed above me there." And prior to that, you have said, "No, I saw the flames", but you couldn't see anything else; it was just black. Is that referring to Flat E at that stage?

Answer: Yes. Inside Flat E.

Question: So when you got access, as it were, to Flat E and could otherwise see inside, what you could see was fire rolling across the ceiling, in all directions, and a black picture, as it were?

Answer: Yes, it was just full of black smoke. It was pitch black. And I went in – I was leaning against this area here, and it was just like flame running all – all the way around the ceilings and back towards me. ...

Question: But you are indicating towards doorway No. 3 or the kitchen/meal area?

Answer: Yes. All I knew, it was – the ceiling was still intact, because the flames were sort of rolling back along the ceiling, towards me.

Question: And how far in terms of metres or feet could you see whatever you could see?

Answer: Oh, it's hard to say. Probably, 10 to 20 feet in front of me.

Coroner: Do you often get into that situation?

Answer: Not, if I can help it, too much. No. I – when I was in there, I had to, several times, duck back into doorway 7, because it was just getting too hot.

Mr Hennessy: You have used terms "major fire", "burning fiercely", "totally involved", is that what you mean by that when you talk about flames rolling over the ceiling and being black?

Answer: That's right, yes.

30 Exhibit 27, pp. 180-181.

Question: You say the northern internal wall was starting to collapse?

Answer: I didn't know that at this stage. All I could see was black and flames, and I was directing a water stream round the room.

Question: When did you learn what you learnt about the wall or ceiling being in a state of near collapse?

Answer: When I was in there 15 minutes, I was told them I had to fall back out of that area.[31]

Senior Station Officer Paul Henderson found his way to the north side of Building 37. From the deck between Flats A and D, he saw a reflection of fire in the windows of Unit 26 opposite. He described the scene of the northern windows of Flat E:

The intensity – the fire was billowing out, rolling out through the windows for the entire length of that building section of windows. ...

Question: Did you gain any vision of them from any vantage point?

Answer: The window area here, which had an aluminium cladding window on it ...

Question: Mr Henderson, when you say that the fire was impinging on the aluminium shutter, can you tell His Worship what the condition of that shutter was?

Answer: In a state of melting disintegration.

Question: Could you see through it?

Answer: Through portions of it, yes.

Question: What did you see through the other side?

Answer: Just a wall of flame. ...

Question: What is your judgment as to the intensity of the fire that was occurring in the bedrooms?

Answer: The fire was most intense, and would have been extremely involved, totally involved.

Question: Mr Henderson, from any vantage point on the decking, were you able to see whether or not the flames were also going through the roof of Flat E?

Answer: Although I couldn't see it, I had a fair indication that, yes, with the intensity of the fire in the living rooms, it would have been through the roof. ...

Mr Bell: Mr Henderson, what did you observe when you opened that door (Door 6) in terms of the state of the fire; how intense was it?

Answer: Well the fire side of it was totally involved. From floor to ceiling it was just a wall of flame with roofing timbers starting to descend.

Coroner: What would the temperature be in there, in your experience as a fire officer?

Answer: It would have – I couldn't actually confirm, but most temperatures in that vicinity would be around the 600 degree mark.[32]

Fire Officer Robert Kelly was also with Henderson.[33] Mr Chea stated in his police interview that he unlocked, but did not open, the locked door 6 upon his third entry into Flat E some minutes prior to Mr Henderson's arrival.[34] The MFB attacked the fire through door 1 between Flat E and

31 Transcript, pp. 705-707.

32 Transcript, pp. 74-77.

33 Transcript, p. 411.

34 Exhibit 268, pp. 29, 44, 45.

Flat B. This occurred at a later stage when the door was so fire damaged that it disintegrated. Thefire was brought under control at 23.29.07 hours.

After the MFB arrived, difficulties with evacuation were still being experienced so the MFB further assisted KRS staff to evacuate the residents. Leading Fire Fighter David Snowden's evidence is but an example of the difficulties associated with evacuating disabled residents, and is illustrative of the need for improvements in training:

> *There was a lot of confusion. We established eventually there was 12 missing. Two had been brought out, which brought it down to 10. One had gone back into the building; he was brought out again. He went back in the building and was then brought back out.*[35]
>
> *... I think the staff should know what would be the procedures, what to do.*[36]

In answer to a question put in evidence, Snowden stated:

> *... it was clear that they apparently didn't know what they should be doing?*
>
> *Answer: It appeared that way.*[37] *...*
>
> *Question: (Had Fire Officer Kelly) ... discussed the reasons why it was such a high risk area?*
>
> *Answer: From my experience I realised it could possibly be a high risk area.*
>
> *Question: Was that partly because of the high occupancy of buildings with residents?*
>
> *Answer: No. I would suggest it was because of the clients themselves.*
>
> *Question: So the fact that because of their disabilities it was going to be a much more difficult job to evacuate them and account for them in the event of a fire?*
>
> *Answer: Commonsense would say that.*[38]

MFB Fire Fighter Ian Morris found Messrs Heaton and Anderson in a bedroom in Flat C and assisted in their evacuation. The two had been missed in whatever evacuation was carried out by KRS staff. Mr Morris stated:

> *We then all made our way to the west entrance of Flat A, where I saw a number of people who appeared to be residents, standing outside that entrance. Senior Fireman O'Keeffe and I then proceeded inside the building via flat A entrance. I decided to go in because I saw people coming out of the Flat A entrance. ... At this stage the smoke in the building was very heavy and thick, visibility was poor. Senior Fireman O'Keeffe and I then proceeded to assist people from the bedroom area in the north/west corner of the building. I'm unsure of how many people we assisted but it was over 6.*
>
> *The residents were all over the place. There was evidence that they were moving around within the building. Some were still in bed, others were in the corridors and we also located one in the toilet. Whilst searching the rooms none of the bedroom doors were locked but the plant rooms were. I can't recall how many or which doors we opened but I can recall that we opened some bedroom doors. Some doors were already opened. We made our way to the area of the Lounge/dining room in flat B before turning back, because we didn't have a line with us and it was too thick to continue safely. We exited via the way we went in.*

35 Transcript, p. 560.

36 Transcript, p. 570.

37 Transcript, p. 570.

38 Transcript, pp. 576-577.

Senior Fireman O'Keeffe and myself then made our way back along the southern wall to the kitchen area, Flat C exit door where we assisted other fireman to run lines in and gained access to the kitchen roof. By the time we made our way to this area the roof on Flat E and part of Flat C had collapsed due to the fire ... (Morris continued searching the building) ... I then located 2 patients who were obviously alive, in a room on the left hand side, but cannot recall which room. I attempted to remove them but was unable to. At this stage my B. A. was running low, so I went outside and grabbed some blokes and re-entered the building. We then removed the patients and exited via the Flat D exit.[39]

At the inquest Mr Morris described the scene inside the bedroom in Flat C (door 21). Again it is illustrative of the difficulties associated with evacuating disabled residents:

Mr Bell: You've described smoke about – what was it – two-thirds of the way down your body, I think it was?

Answer: Yes, about that – that far down, yes.

Question: How far in front of your face, standing, could you see through that smoke?

Answer: Probably maybe six feet if I was lucky.

Question: If you got down under the level of the smoke – – –?

Answer: Under the level of the smoke I could – could see a fair way. ...

(On finding the residents) Question: These two people were in the one bed; is that right?

Answer: I believe one was in a bed at the end of the bedroom here (indicating) and there was another man here (indicating). I believed he was on a bed but he could quite possibly have been on the floor. I don't – he was – – –

Question: I see, so they weren't in the same bed?

Answer: No. ...

Question: What was the state of the smoke in that room? – It actually wasn't too bad.

It wasn't too bad?

Answer: Because the door had been closed.

Question: Yes?

Answer: There was a fair bit of heat damage to the door, so – indicated the fire had been close by, but in that particular room itself there wasn't much smoke.

Question: Was the door closed when you got to it? – The door was closed when I got there. ... It wasn't locked.

Question: You came into that room, and I just want you to try to tell me what was the state of their consciousness as best you can remember?

Answer: Fairly much asleep, if I remember. They weren't very conscious at all. I shook one and he opened his eyes and looked at me and – but it was fairly hard to tell – – –

Question: Whether he was asleep or not?

Answer: They were disabled and – and I – it was fairly hard to tell in what state they were.

Question: Could you tell whether or not they were asleep or just terrified?

Answer: I couldn't say. ...

Question: Now, you say that you tried to remove them. What did you do to try to remove them?

Answer: I tried to pick them up, and by that stage we'd done so much work everywhere else that I'd just about worn myself out.

39 Exhibit 38, p. 174.

Question: Had you?

Answer: So I decided to get outside and get some help.[40]

The MFB Submission makes the point that the residents *'had to be medically treated but were unharmed. The fact that they could not evacuate themselves, and had to be evacuated by Mr Morris, demonstrates the possible consequences that might have flowed had the MFB not been able to respond early to attack the fire and assist in the evacuation'.*[41] The submission also states that the evidence establishes *'that there were several problems encountered by MFB personnel in the conduct of the fire fighting effort and the evacuation, and KRS staff gave evidence about the difficulties which they themselves encountered'.*[42]

It is found that all KRS staff performed their tasks to the best of their ability given the level of training and support. The MFB firefighters involved in the emergency performed their tasks in a professional manner. For both KRS staff and the MFB, it was a highly stressful and difficult situation.

The evidence also establishes that the MFB promptly responded to the alarm call, arriving five minutes 37 seconds after the call. The response of other units thereafter was equally efficient. The fast response of the MFB to the alarm of fire obviously saved lives.

1.6 SOURCE AND CAUSE OF THE FIRE

The fire has been identified as originating at resident Paul's bed in a bedroom in Flat E.

1.6.1 SOURCE AND CAUSE OF THE FIRE

Mr John Kelleher, scientist, Forensic Science Centre, in describing the location of the source of the fire, related that:

> *[i]n the doorway, the floor was quite sound, but an increase in depth of charring was evident towards the window at the north end of the room. In the centre of the northeastquarter this room, there was a hole burnt through the floorboards, of approximately 250 square centimetres, which probably resulted from increased ventilation through a join in the floorboards. Beneath the window, at the foot of the bed closest to the window, the floorboards had been completely consumed over an area of approximately 1.5 square metres. There was a further large hole in the floor, approximately 0.2 square metres, towards the head of the bed and between the bed and the wall.*
>
> *In addition to the pattern noted in the burning to the floor, there was a progression of damage apparent in the bed frames in this room. While all the metal frames were heat-affected, those closer to the window were more severely damaged, and had buckled further on the northern side. ...*
>
> *There was no material or timber remnants at floor level, and the arrangement of the debris was consistent with the floors being clear and the wardrobe doors being closed. This distribution of material indicated that the fire developed away from the wardrobe, but produced sufficient heat to char the outer surface of the wardrobe, with the burning contents eventually collapsing onto the charred floor.*

40 Transcript, pp. 920-921.

41 MFB Submission, p. 39, para. 90.

42 MFB Submission, p. 39, para. 92; see discussion in the Findings in **PART 3 Management of Risk and System Deficiencies 3.8 Fire Drills and Evacuation Procedures.**

There were no electrical appliances or wires in the vicinity, nor was there any other apparent potential source of accidental ignition. There were no cigarettes, matches, lighters, ashtrays or other smoking materials identified either in the debris or elsewhere in the premises. I concluded that the fire was probably ignited directly, by means such as a match or cigarette lighter, although a smouldering cigarette could not be excluded ... .[43]

The MFB simulated the fire by a series of 'fire test' in a building specially constructed to reproduce as far as possible the conditions in Flat E on the night of the fire. After observing the 'fire test' (with a cigarette lighter being used to ignite bedding), Mr Kelleher concluded:

- the bedding could be ignited readily with a match or cigarette lighter, but the mattress cover was much more difficult to ignite.

- heat from the burning bedding degrades the mattress cover, so that collecting bedding at one end of the bed is likely to speed the development of a fire.

- burning material from the bedding and mattress makes a significant contribution to low level burning, as burning material pools on the floor below the bed.

- within two to three minutes of ignition, the level of smoke would be sufficient to incapacitate any persons in the room.

- the difficulty associated with igniting the mattress was such that ignition by a smouldering cigarette must be regarded as a remote possibility.[44]

Mr Kelleher also concluded:

[i]n my opinion, the results of the last test, on Friday 5 July 1996, supported my earlier conclusions regarding the point of origin of the fire. After observing this test, and examining the data recorded at the time of the test I believe the fire was probably ignited in bedding, by a match or a cigarette lighter. The apparent speed of the original fire relative to the test burn and to the observed pattern of burning of the bedding, suggested that the bedding may have been ignited in more than one place.[45]

Inspector Gary Martin, MFB Fire Investigation Unit, supported Kelleher's conclusion:

Given the burn patterns within the structure and the degree of damage around the area of the bed located adjacent to the north wall of bedroom 1, Flat E, this fire is consistent with one having its origins in or near the bedding of that bed. A thorough investigation did not reveal any signs of an accelerant nor any evidence of any other introduced fuel. There was no evidence of any material that may be subject to spontaneous heating.

Excavation of the area did not reveal any signs of a source of ignition therefore one would have to be introduced. These facts lead to the conclusion that this fire was ignited by way of an introduced source of ignition, consistent with a cigarette lighter flame, in contact with bedding on or near the bed adjacent to the north wall of bedroom 1.[46]

The scene was also examined by Mr McCumisky, MFB Electrical Inspector. The possibility that the fire was caused by an electrical fault was also excluded by McCumisky.[47]

43 Coroner's Brief – Police Arson Squad, pp. 388-389.

44 Coroner's Brief – Police Arson Squad, pp. 390-391.

45 Coroner's Brief – Police Arson Squad, p. 390. See also Mr Kelleher's evidence generally in the Transcript, pp. 2625-2714.

46 MFB Report, p. 41.

47 MFB Report, p. 41.

The experts, Messrs Daryl Knight and J. P. England in the Warrington Fire Research Report, essentially agreed with the conclusions of Kelleher and Martin as to the probable source and method of ignition.[48]

On the expert evidence it is reasonable to conclude that the fire was caused by ignition of bedding by a cigarette lighter flame in contact on or near the bed located adjacent to the north wall of bedroom 1 (door 3) of Flat E.

1.6.2 POTENTIAL INVOLVEMENT OF A RESIDENT

There is an identified sequence of events that may lead to a conclusion that an intellectually disabled resident lit the fire. As the resident did not have the required knowledge of the consequences of his action, it is not considered appropriate to disclose his name in these Findings. Accordingly, he will be referred to as Paul. In addition, an order is made restricting the publication of his name beyond the description Paul.

1.6.3 LEAD-UP TO THE FIRE AND LATER EVENTS

A number of witnesses gave evidence as to Paul's interest in cigarette lighters during the day of the fire.

On the morning of the fire, Paul and other residents had been taken to Trianda, a hobby farm. At the farm, one member of staff – Ms. Zsar Noter – saw him making noises and giving hand gestures as she picked up a cigarette lighter.[49] Another staff member, Ms. Xanthe Vine, observed Paul seeking to direct the attention of staff towards the cigarette lighter. [50]

The sequence of events is adequately described in the submission of the Parents' Association as:

> *Paul was directly observed by staff on that day in possession of a cigarette lighter on at least two separate occasions, showing an interest in the lighters, and a preoccupation with them. Pragnaratne saw a lighter in the kitchen at Trianda hobby farm, but left it there in case someone else wanted it. Noter and Vine took the Flat E clients to Trianda on 8th April and whilst upstairs cleaning, Paul found a rusted green lighter and became excited, pointing and making noises. The lighter did not work and was discarded in the rubbish bag. Later back at 30/31 one of the rubbish bags which Paul was helping carry broke open, and the rubbish had to be re-bagged.*[51]

After the group arrived back at KRS, Mr Arthur Andreopoulos removed a cigarette lighter from Paul. This occurred at approximately 5.15 p.m. at the Units when Andreopoulos was shown a cigarette lighter by Paul. Andreopoulos states:

> *That evening around 5.15 p.m. the clients from D and E flats commenced having their tea together outside on the verandah between D and E flats. I was just finishing tea when I saw Paul with a cigarette lighter. He was holding it in his hand and showing it to me. When he finds something he normally says 'Good Boy', but I can't remember if he said it this time. I took it off him and tried it to see if it worked but all I got were sparks, it wouldn't light. I told Paul to sit down, pointing to his chair. I didn't notice if there was any fuel left in it. It was a small cigarette lighter about half the size of a normal BIC lighter. After taking it off him I showed it to Zsar and she said that he had found a lighter at the*

48 See Exhibit 201– Warrington Fire Research Report, p. 10; Exhibit 212 – Knight's Report, p. 6.

49 Coroner's Brief – Police Arson Squad, p. 93; Transcript, p. 1356.

50 Coroner's Brief – Police Arson Squad, p. 96; Transcript, p. 1449.

51 Parents' Submission, p. 69, para. 206.

farm as well and something like, 'That's the second time today.' She also mentioned that the one at the farm wouldn't work. At that moment I felt glad that I had found Paul holding the lighter, that I had taken it off him and that it did not work. I had my jacket on a table with my keys and a packet of cigarettes with my cigarette lighter inside the packet, and I put this other cigarette lighter on the table with these things.

That was the last I saw of that lighter. My jacket and belongings are normally locked away but at about 5.00 p.m I took them out from the D flat kitchen as Praveen and I were having a cigarette and coffee on the verandah waiting for the E flat clients to arrive. The E flat clients arrived late and we had to quickly set up for tea. During tea my belongings were always in my view and after tea the clients go to their flats and go about their usual night routine. They do not have access to the verandah after tea.

After tea we started to clean up and two of the boys, Paul Coffey and Paul wiped down the tables. Shortly after at about 6.00 p.m. Zsar took her ten clients into E flat and Praveen and I took our clients into D flat. Our clients sat down to watch T.V. in the flat. I left work at about 6.35 p.m. leaving Praveen with our clients. Just before leaving I picked up my jacket, keys and cigarettes from the table where I had left them. When I arrived at home I realised I didn't have the cigarette lighter that I had taken off Paul, but I didn't think anything more of it. I didn't ring back because I didn't consider the lighter to be a danger as it did not work. I considered it to be a piece of rubbish. I still had my own cigarette lighter and cigarettes with me. It was not until the Wednesday after the fire when a staff member mentioned that Paul had been apparently found with a lighter when he was pulled out of the fire, that I remembered that I had seen him in possession of one on the Monday. I told Zsar about this straight away.[52]

Mr Andreopoulos described taking the lighter from Paul to Noter, and this was observed by Pragnaratne.[53] Noter considered that the lighter was similar to the one at the hobby farm.

The lighter found in Paul's possession after the fire was not the lighter from the farm nor that taken from him by Mr Andreopolous. This is because neither of these lighters worked.[54] However, the lighter found with Paul after escaping the fire was capable of being struck and had fuel.[55] The evidence of Ms. Catherine Backhouse links Paul to an operating lighter shortly after the fire. Backhouse, an Intellectual Disability Services Officer, who was on duty in Unit 21 on the night of the fire, stated:

When I was getting the clients out on one occasion I saw one of the clients who I was handling out of the doorway (to the kitchen/dining room door [door '15' on the plan]) was flicking what seemed to be a cigarette lighter. As I moved the group towards the garden bed I saw this client pick up a piece of paper (or something similar) from the garden bed and attempt to light it with the lighter. I intervened and snatched the lighter off him and made sure the paper hadn't caught fire ... .[56]

When describing the incident, Backhouse said that she saw *'a naked flame going on and off as someone was approaching me'*.[57] This was in the building. Some of the difficulties that confronted Backhouse (and other staff) are illustrated in this exchange about the lighter:

52 Exhibit 86.

53 Transcript, pp. 1300, 1357.

54 Coroner's Brief – Police Arson Squad, p. 93; Mr Andreopoulos' evidence in Transcript, pp. 1543, 1549; Coroner's Brief – Police Arson Squad, pp. 99-100.

55 Exhibit 79 – 'Cigarette lighter'; see comments in Coroner's Brief – Police Arson Squad, pp. 389-390.

56 Coroner's Brief – Police Arson Squad, p. 128.

57 Transcript, p. 1881.

Mr Bell: ... I take it you have never been in a smoky room before?

Answer: Never.

Question: Of that kind?

Answer: No.

Question: And I take it that you were absolutely terrified?

Answer: I was scared.

Question: Would that be a fair description?

Answer: Scared, yes.

Question: You knew that there was a raging fire on the other side of the building, didn't you?

Answer: In the middle. Well, I could see it was – – –

Question: You had never been in any situation like that before?

Answer: No.

Coroner: But you still went into the building?

Answer: I had to get clients out.

Mr Bell: You had to get the clients out, and you went as far into the building as you thought you possibly could?

Answer: Yes.

Question: It was on that first occasion that you have described a group of clients coming towards you; are you okay, Miss Backhouse?

Answer: Yes. ...

Question: That is so ... it was then you saw a client with a lighter; is that right, as he was coming out?

Answer: Someone was approaching ...

Question: Yes. I just have to put to you, Miss Backhouse, that there is no fire officer has seen what you saw at that particular time and I want to suggest to you that maybe your memory is faulty in that regard?

Answer: No, I definitely saw the lighter – the flicker – the flame coming towards me.[58]

In evidence, Ms. Backhouse also confirmed seeing a flame coming from a lighter during the later incident near the garden bed.[59] She stated that she saw the same person pick up paper or something similar and try to light it. She described these events as follows:

... As I moved the group toward the garden bed wall I saw this client pick up a piece of paper from the garden bed and attempt to light it with the lighter. I intervened and I snatched the lighter off him and made sure the paper hadn't caught fire. I did not know this person because he was not from my unit. I kept the lighter in my hand and then I realised that some of the clients were wandering back into the building so I was chasing them back to the garden wall. I was at this stage being assisted by other staff members. I recall seeing Peter Ansorge there but I can't remember who else was there. I saw night supervisor Craig Free there and I told him that I had seen a client with a lighter and I showed him which one it was.

58 Transcript, pp. 1901-1902.

59 See generally Transcript, pp. 1850-1903.

The next thing I recall I was being assisted by other staff members carrying one client back to unit 21. He was very heavy and was not being helpful. As we walked down the walkway he was lashing out with his feet which caused me to drop the lighter on the walkway between unit 30 and unit 21. I also dropped the fire keys which I managed to pick up. I could not find the lighter and was more concerned with the welfare of the client so I continued back to unit 21.[60]

The resident with the lighter was pointed out to police by Backhouse as being Paul.[61] The fact that Paul had access to lighters on several occasions during that day is an unhappy comment on the State of Victoria's resident management system.

The clothing that Paul was wearing when he escaped from the building was examined by Mr Kelleher and found not to be fire or smoke affected.[62] Paul was not injured in the fire.[63]

An examination of staff knowledge of Paul's behaviour and the risk for fire is discussed later in the Findings in **Part 3 Management of Risk and System Deficiencies 3.9 Management of Fire-lighting Risk by DHS**. One example of behaviour potentially identifying him as a risk factor can be seen in a statement by Mr Praveen Pragnaratne, Intellectual Disability Services Officer. He said:

I have seen Paul handling the cigarette lighters of staff members and I have once seen him try to light a staff member's cigarette lighter. On this occasion he held the lighter in one hand and tried to light it with the thumb or index finger of the other hand. I remember it because he burnt his finger by purposely putting a finger on the flame after lighting it. He did this before I could take it off him ... .[64]

Evidently, this incident occurred sometime in 1995, prior to the fire. The incident was neither noted nor drawn to the attention of supervisors. Pragnaratne, who cared for ten clients in Flat D (and E), had not read Paul's file. Another witness, Ms. Leslie Vincent, observed Paul lighting a newspaper in 1993. Again this incident was not recorded. It would seem that the failure to record incidents of this nature or to read files thoroughly was not an unusual practice among the staff.

1.6.4 CONCLUSION AS TO THE CAUSE OF THE FIRE

On the issue of whether Paul caused the fire, the Public Advocate submitted that *'[t]he scientific evidence suggests that the seat of the fire was Paul's bed but the exact circumstances of the ignition, which can be said to have occurred without accelerant, remain a mystery'*.[65] Against this argument is the MFB fire test which demonstrates how a cigarette lighter can be used to ignite bedding in a short time and without accelerant. The submission suggested a number of alternatives, which are:

- someone else was responsible for the fire, by direct or indirect means;
- someone was responsible, directly or indirectly, for it, in company with Paul; or
- Paul ignited the fire directly or indirectly using bedding.

It is also stated in the Public Advocate's Submission that:

60 Coroner's Brief – Police Arson Squad, p. 127.

61 See Transcript, pp. 1903-1904; see also reference to statement by Detective Sergeant Peter O'Connor in Coroner's Brief – Police Arson Squad, p. 356. See also O'Hare in Transcript, p. 2287; Detective Senior Constable Wheeler in Brief, p. 358; Detective Senior Constable Robertson in Brief, p. 393; Exhibit 51 – Inspector Chielmnik's statement, p. 2, evidence in Transcript, pp. 1084-1085, 1090.

62 Transcript, p. 2635.

63 Transcript, p. 1096.

64 Exhibit 78.

65 Public Advocate's Submission, p. 42.

[a]s multiple hypotheses for the proximate cause of the fire and consequential deaths of the deceased are feasible, there being no eyewitnesses or clear evidence, and as thepossibility of complete accident cannot be ruled out, [it is submitted] that there does not exist sufficient evidence for a finding on the Briginshaw standard that Paul was responsible for the fire.[66]

Further, the Public Advocate argued to the effect that there is insufficient evidence on the source of the cigarette lighter. This is also supported in submissions by Paul's counsel who, in addition, argued that the simple fact of Paul's possession of a lighter after the incident is *'in no way conclusive as to how long he had it'*.[67] Counsel suggested that there may be others in the vicinity of the point of ignition with both access to the lighter and the capacity to ignite. Counsel also made the point that access to lighters may have occurred in a number of ways to other residents as well as to Paul. It is argued that he may have picked the lighter up after the fire was lit by another resident.

The Parents' Submission dealt with this issue, and commented that *'[i]t is distinctly possible that if the particular lighter found in Paul's possession by Ms Backhouse was not obtained by him that day, then it was one he had stored in his room or his bed, as was frequently his habit with items he collected on a daily basis at KRS'*.[68] While there is evidence from Mr Frlan about Paul keeping lighters,[69] counsel for Paul argued that *'there is no actual evidence of him ever secreting one in his room'*. Another point made by counsel is that Paul's observed behaviour after the fire was not consistent with the fact that *'he would have looked downcast if in trouble'*.[70]

However, there is sufficient evidence establishing that the fire was set alight by Paul, which is as follows:

- The fire began at Paul's bed.[71]
- Paul was the only occupant of Flat E to escape.
- Paul had the motor skills to light a fire with a cigarette lighter.
- On investigation Paul was found to be a fire-lighting risk.[72] He had demonstrated a capacity to light an object.
- Paul collected objects, including cigarette lighters.
- Paul demonstrated an interest in cigarette lighters on the day of the fire.
- Shortly after the fire alarm was raised, he was seen leaving the building flicking a cigarette lighter and was seen trying to light paper with that lighter.
- The cigarette lighter found in Paul's possession after the fire was working.[73]

While there may be other possibilities, there is sufficient evidence for a finding, to a comfortable degree of satisfaction, that Paul used a cigarette lighter to ignite his bedding. What is clear is that he did so without any knowledge of the consequences of his actions.[74]

66 Public Advocate's Submission, p. 42.

67 Submission by Counsel for Paul, p. 7.

68 Parents' Submission, p.70, para. 211.

69 Transcript, p. 2419.

70 Submission by Counsel for Paul, p. 17.

71 As identified by Ms. Noter at Transcript, p. 1354; see also the conclusions in the Findings in **PART 1 The Fire, its Aftermath and Cause 1.6 Source and Cause of the Fire.**

72 See the conclusions in the Findings in **PART 3 Management of Risk and System Deficiencies 3.9 Management of Fire-lighting Risk by DHS.**

73 Twenty-five per cent of fuel remaining in the lighter: Mr Kelleher in Transcript, p. 2635.

74 See conclusions in the Findings in **PART 3 Management of Risk and System Deficiencies 3.9 Management of Fire-lighting Risk by DHS.**

PART 2 KNOWLEDGE OF RISK AND SYSTEM DEFICIENCIES

In this Part the history of previous fires and false alarms at KRS are considered.

Numerous fire brigade reports on deficiencies in the fire safety system at KRS are detailed from the late 1980s.

In addition, there are several consultants' reports on the fire safety systems from 1992. These are the 'Lumley Report', the 'Dibben Report', the 'Umow Lai Report' and the 'Fabric Survey'. The 'Umow Lai Rreport was presented to KRS in August 1994, and culminated in the moves to upgrade the fire safety system by introducing an 'addressable detector' alarm system and partial residential sprinklering throughout the residential section of the complex. At the time of the fire, the new system was only partially installed and not operational. Umow Lai made a number of additional recommendations which were not followed. The extent of the scope of the Umow Lai Report (and fire audit) is considered. It is noted that the earlier Dibben Report (1993) was viewed by a branch of the Department of Human Services (Capital Management Branch) as being 'technically flawed' and not shown to either KRS or Umow Lai. The Dibben document is considered to be a significant report in that it took a 'holistic' approach to the management of fire risk at KRS. The Umow Lai Report, although dealing in part with many of the management issues Dibben covered, focused on an 'engineering' solution. When read together, both the Dibben and Umow Lai reports showed that many of the issues raised in the Lumley Report had not been properly addressed.

Coroners' inquests and recommendations dealing with fire and safety for the elderly, infirm and disabled are also considered. Issues such as the use of smoke alarms and sprinkler systems, fire audit, managing of fire-lighting behaviour and evacuation procedures have been dealt with by coroners from the early 1990s. A strikingly similar fire in 1968 at Willsmere Mental Hospital (on the KRS site), which resulted in six deaths, is examined.

Concerns were also expressed by the Community Visitors and by the Kew Cottages & St. Nicholas Parents' Association.

Government directives from the early 1990s dealing with significant reforms of building law as it applies to the public sector are considered. These directives are aimed at improving safety levels in government buildings. Information from government agencies requiring the installation of smoke detectors is cited.

This Part emphasises the existence of over ten years of warnings to various governments and their agencies with a responsibility to care for intellectually disabled residents at KRS. Indeed the potential for a tragedy of this magnitude was foreshadowed by the Willsmere fire on the same site in 1968, which resulted in the deaths of six residents of the Mental Hospital. On that occasion the MFB called for the introduction of sprinkler systems. In spite of these warnings, the recommended fire hardware safety systems had not been completed by the time of the fire. Nevertheless, there was considerable progress towards hardware solutions in the form of a new addressable alarm and partial sprinklering. Recommended management systems aimed at fire safety had not been adopted; these included improvements in fire drills and evacuation procedures and auditing of maintenance.

The totality of the warnings form the basis of a determination of contribution to the deaths by the State of Victoria, which owed a duty to protect residents under its care by providing an efficient, safe and proper fire safety system.

2.1 PREVIOUS FIRES AND FALSE ALARMS AT KRS AND WILLSMERE

The Metropolitan Fire Brigade Report (MFB Report) about the fire summarised the history of recent fires (between 1963 and 1996) at KRS as follows:

> *Kew had a long history in terms of fires, with a fire in 1952 severely damaging a school located within the grounds.*
>
> *These fires continued over the years and research by the Brigade has revealed that in the period between 1963 – 1983, the combined fires at Willsmere and Kew Cottages totalled 106 and the period between 1983 – 1996, 16 fires occurred at Willsmere with 66 fires at Kew Cottages.*[1]

The MFB Report provided a statistical summary of the fires and false alarms for a 33-year period. Whether attendance was for a false alarm or a fire, the figures demonstrate that attendance of the fire brigade was a regular part of life at KRS. The summary is as follows:[2]

SUMMARY OF FIRES AND FALSE ALARMS TO WILLSMERE AND KEW CHILDREN'S COTTAGES 1963-1996

Summary of Fires

1963 – 1983 Willsmere & Kew Cottages	106
1983 – 1996 Willsmere	16
Kew Children's Cottages	66
Total	172

False Alarms Between (1983-1996 only)

Willsmere Total False Alarms	159
Kew Children's Cottages False Alarms	475
Total	634

1 MFB Report, p. 1.

2 See MFB Report, p. 2.

Cause

Workmen:	painters, oxyacetylene cutting etc.	3
Patients:	smoking materials, matches, suspicious circumstances etc.	20
Unknown/Unreported:	where cause cannot reasonably be proved or details are not reported	85
Spontaneous ignition:	briquettes	3
Electrical appliance fault or malfunction		16
Radiated heat		4
Spark from open fire/rekindle		3
Chimney fire:	foul flue	2
Flammable vapours in contact with naked light		1
Automotive/ Mechanical		2
Unattended		6
Accidental		27
TOTAL		172

Areas of origin

Fires involving building structures	90
Fires involving detached buildings	9
Rubbish & Grass Fires	44
Electrical Appliances	12
Machinery	3
Unknown/ Not reported	6
Maintenance areas	8
TOTAL	172

Main Structure area of origin

Wards/ Sleeping areas	29
Residential nursing quarters	5
Chimneys	2
Administration areas	8
Kitchen/ Dining	33
Lounge	2
Unknown/ Not reported	5
School/ Teaching	1
Occupational Therapy	5
TOTAL	90

A false alarm rate of 634 for the period 1983-1996 is of concern. In its Submission, the MFB argued that '*a high incidence of false alarming undermines user confidence in the system*'. It pointed to the fact that '*[m]any of the staff involved in the rescue on the night of the fire thought that the alarm of fire was yet another false alarm*'.[3] Further, the MFB stated that:

> *[e]ven one of the staff members in the unit where the fire occurred (Mr Frlan) felt that he had to check on the authenticity of the alarm because it might have been just another false alarm … .*[4]

The submission makes the point that such '*a state of affairs is not compatible with optimum life saving effort, although only minimal inefficiencies resulted from this on the night of the fire'*.[5] Nevertheless, the high incidence of false alarms may well have influenced the practice of changing smoke with thermal detectors. This issue will be discussed later in the Findings.

As part of its submissions, the Villamanta Legal Service prepared the following table of 'fires' for the 11-year period ending April 1996. Additional material is provided in Appendix 2.6 of the Findings. The Villamanta Legal Service's table is as follows:

Summary

Year	Number of MFB attendances	Fires involving human element, and cigarettes, lighters or matches	Kitchen fires involving burnt food
1985	8	3	0
1986	4	1	0
1987	4	2	1
1988	5 (+2 for the same fire)	4	0
1989	2	0	0
1990	2	0	0
1991	1	0	0
1992	0	0	0
1993	14	0	11
1994	16	1	12
1995	5		2
1996	2		
TOTAL	63 (+2)	11	26

The table was prepared by the Legal Service '*to prove that fires were a constant part of life at Kew. Since 1991 until the fire on 8 April 1996 there were 38 fires at Kew, 25 of these relate to burning food. One fire involved a resident, matches or lighter. It is an average of 6 fires a year'*.[6] It is noted that a number of the fires relate to call-outs for incidents such as 'burning toast' etc. Accordingly, there must be some caution as to how the total figures are interpreted. However, the figures still lead to the conclusion there was considerable data on the risk and likelihood of fire at KRS during this period. This issue will be further considered in the conclusion to this Part.

3 MFB Submission, p. 106, para. 187.

4 MFB Submission, p. 106, para. 187.

5 MFB Submission, p. 106, para. 187.

6 Villamanta Legal Service Submission, p. 37.

2.2 MFB REPORTS, CONSULTANTS' SURVEYS, INQUESTS AND DEPARTMENTAL DIRECTIVES

2.2.1 INTRODUCTION

A study of several MFB fire reports and of consultants surveys indicate a plethora of continuing problems in fire safety systems at KRS. The State of Victoria has issued various directions as to the requirement for smoke detectors and departmental compliance with building law. These provide the State's broad direction to its own departments on important aspects of fire safety. In addition, a number of coroners' inquests over the years have identified problems and posed solutions to issues associated with fire safety and the disabled or infirm.

In order to understand safety issues surrounding the fire and the level of knowledge of risk within the agencies charged with the care of the residents, it is necessary to review these many reports. It must be noted that DHS (or its predecessors) may not have obtained prior access to all of the detail in the fire brigade reports.

2.2.2 MFB REPORTS

In some of the MFB fire reports between May 1969 and April 1993, comments have been made about various fire safety issues at KRS. A reading of each report, and a consideration of the documents as a whole, points to a long history of serious weaknesses in systems relative to fire prevention and protection. The detail in those reports are to be found in Exhibit 171.

Significant comments drawn from the reports are as follows:

(1) Fire Report 26/5/1969
From Superintendent N. J.Steel to the Chief Fire Officer. It is a detailed report into fire safety issues at the Kew complex, in which the comment is made:

... It is the considered opinion of the Brigade that in institutional occupancies where the inmates are not able to help themselves and/or are under lock and key the only proper protection is a system of automatic sprinklers.[7]

(2) Fire Report 15/4/1972
From District Officer J. R. Hunter to the Chief Fire Officer. This report deals with the construction of two new wards, each containing 16 beds, and it is said:

As a general recommendation, and this would apply to all mental institutions, where patients are confined during sleeping hours, the Brigade considers that the only suitable protection to obviate the life hazard is the installation of automatic sprinklers.[8]

The report further comments that, following detailed brigade reports in 1965 and 1968, *'some of the recommendations ... have been carried out and others are being considered as money becomes available'*.

(3) Fire Report 7/8/1979
From Station Officer J. S. Gray to the Chief Fire Officer. This report deals with exits for Wards 21, 22, 23 and 24, and recommends a permanent concrete ramp and wider exit doors *'because of the type of patients (Non-Ambulatory)'*.[9]

7 Exhibit 171 – Fire Report, p. 8 (9 pages).

8 Exhibit 171 – Fire Report, pp. 1, 2 (2 pages).

9 Exhibit 171 – Fire Report (no. 79.1895; 2 pages).

(4) Fire Report 15/8/1986
From Station Officer T. George to the Chief Fire Officer. This report is a comprehensive audit of the fire safety systems in each building at Kew. During the inquiry it has been referred to as the 'Dobson Report'.

In the introduction to the report, the Brigade comments to the effect that its purpose *'is to provide an acceptable level of fire protection and safety'* and that it is *' mindful of the fact that the majority of the buildings have been built for a considerable number of years and fire safety standards have not been maintained in accordance with current regulations'*.[10] Principally, the report does not develop the argument for 'sprinklers' nor does it refer to 'smoke detectors'. Rather, it recommends the installation of 'thermal detectors' and the extension of the existing ringed fire main. Other areas of recommendation include the requirement that:

[a]ll fire and safety equipment ... be maintained in accordance with Part 59 of the Victorian Building Regulations. Each hydrant, hose reel and extinguisher [is] to be mounted and indicated in accordance with Commonwealth Fire Board circular No.2 "Fire Fighting Equipment Mounting and Indication of Fire Emergency Signs".[11]

In addition, the report comments that *'required exit doors were not indicated and were kept locked at night'*[12] and that *'provision* [is] *to be made for a remote control mechanism to ensure all exit doors* [open] *simultaneously should an evacuation be required'*.[13] On inspection of 'Building 37', Unit 30 was vacant while Unit 31 comprised dormitory-style accommodation for 31 residents. The report commented that *'hose reels were not fitted; portable fire extinguishers were free standing and were not indicated; required exit doors were not indicated'*.

Further, the report recommends the extension of the existing ringed fire main, that the main be fitted with hose reels and that exit signs and emergency lighting be brought within the requirements of the Victorian Building Regulations:[14]

All fire and safety equipment ... be maintained in accordance with Part 59 of the Victorian Building Regulations.[15]

(5) Fire Report 15/4/1988
From Senior Technician J. Bromley to the Systems Services Manager. This report notes *'that many of the units had no form of fire protection. The units identified are 1, 2, 6, 10, 11 and 12'*, and it is stated further that *'other problems concern Operations, Fire Protection, and Fire Equipment Services'*. The report highlights:

... 1. Fire Drill Training
No form of Fire Drill is in place. Consequently, Mr Peterson will contact S.0. Roy Tucknott from the Training College for advice and training in Fire Drill procedures.

2. Lack of Audible Fire Alarms
Appliances turning out to a call at a Cottage Unit have been informed by the Charge Sister that she was unaware that an alarm call had been generated to the Brigade.[16]

10 Exhibit 171 – Dobson Report, p. 2 (63 pages).

11 Exhibit 171 – Dobson Report, p. 29.

12 Exhibit 171 – Dobson Report, p. 29 (refers to Building 20, Unit 11).

13 Exhibit 171 – Dobson Report, p. 30 (refers to Building 20, Unit 11).

14 See Exhibit 171 – Dobson Report, pp. 51-52.

15 Exhibit 171 – Dobson Report, p. 51.

16 Exhibit 171 – Fire Report (note: of five points only two have been referred to by way of example) (2 pages).

Senior Technician Bromley also mentioned that a meeting was held on 13 April between himself, Messrs Daryl Peterson (Kew) and Ken Quinn (Wormalds) at which it was agreed (omitting other points) that Wormalds would provide a quote for the *'installation of buzzers in each unit (to provide audible warning), BGAs into internal supervised areas, and to re-connect all units to the fire alarm system'.*

(6) Fire Report 18/4/1988
From Station Officer W.R. Mackwell to the Chief Superintendent Operations. This report, which followed a meeting conducted at Kew Cottages on 11 April between Fire Brigade officers and an Acting Manager, 'Children's Cottages', states, after commenting on unserviceable break-glass alarms:

... 2. Audible warning system to be installed in the supervisors office in each unit.
3. That the management request the Fire Prevention Department to conduct lectures to all staff on the procedures to adopt in the event of fire.
4. That the functions of the safety engineer at 'Children's Cottages' to be reviewed and upgraded with the possibility of making the position a full time job ...
7. That the management implement the recommendations as laid down in the Fire Protection Report' dated August 1986.[17]

(7) Fire Report 19/1/1989
From Station Officer J. P. Russell, Fire Investigation Unit, to the Chief Superintendent Operations. This report relates to a fire that occurred in the staff room of O'Shea Building on 18 January 1989, and it indicates that the source was in the vicinity of a plastic rubbish bin and that there was no *'physical nor mechanical ignition sources evident at the point of origin'*. Mr K. Wier, the fire investigator, noted '*a large glass ashtray with a number of cigarette ends on a table in the hallway adjacent to the door of the staff room'*. After commenting on the possibility that the window to the staff room was broken before the fire, it is stated:

As a safety precaution I advised Mr Koutoulas [Unit Manager] *to tighten security on the inmates as to the availability of cigarette lighters and matches which exists.*[18]

(8) Fire Report 23/1/1989
From Station Officer W. R. Mackwell to the Chief Superintendent Operations. Evidently, an inspection on 23 January prompted Mackwell to write:

In two earlier reports dated 4th April 1988 and 18th April 1988 ... I found a number of faults with the auxiliary alarms and made a number of recommendations, and after follow up inspection on 23/1/89 I found that the alarms have not been fixed and the recommendations have not been implemented.

I spoke to Wayne Dobson, Manager Kew Cottages, and he said that as far as he knew, it was in the hands of the Public Works Department – Ministry of Housing and Construction.

I find it appalling that after 9 months, since my first report that nothing has changed, and I recommend that this be followed up by Chief Superintendent Fire Safety.[19]

(9) Fire Report 15/4/1993
From Station Officer (Community Safety) T. McCarthy. This report was prompted by a fire on 16 January 1993 in Building 35. The fire '*appeared to involve a washing machine situated in the laundry of Unit 19'*, and it is stated:

17 Exhibit 171 – Fire report (3 pages).

18 Exhibit 171 – Fire Report, p. 2 (3 pages).

19 Exhibit 171 – Fire Report (1 page).

2.1 A thermal detector fixed to the ceiling of the laundry did not activate the fire alarm possibly due to insufficient heat being generated from the fire before it was extinguished (Note: the thermal detector was subsequently tested and operated correctly).

2.2 The building consists of approximately 24 intellectually handicapped patients and eight (8) daytime staff while only one (1) staff member supervises at night.

Note: Building 35 is typical of a number of other buildings (in construction and style of occupancy) contained within the site known as Kew Cottages.

2.3 Fire resisting type of construction and separation did not appear to be adequate between shared occupancy units and common roof space.

2.4 A number of exit doors were fitted with automatic unlocking mechanisms and did not appear to be connected to a fail-safe (manual) control switch or a fail-safe device which automatically unlocks the door upon the activation of the Automatic Fire alarm installed in the building.

Note: Mr Lim (Unit 19 Supervisor) indicated that exit doors are locked during the night time in order to prevent patients wandering outdoors. Due to the patient/staff ratio at night, it is quite possible that in the event of fire, evacuation of all Occupants would be delayed because of the locked doors.[20]

McCarthy recommended, with a copy being sent to Messrs Peter Lim, Unit Manager and John Taylor, Facilities and Services Manager:

3.1 In lieu of providing horizontal fire separation within the building provide an automatic sprinkler system that conforms with the AFPA/AAFA – "CODE OF PRACTICE FOR INSTALLATION OF RESIDENTIAL LIFE SAFETY SPRINKLER SYSTEMS" to the satisfaction of the Chief Fire Officer. (Refer Item 2.3).

NOTE: The aforementioned sprinkler system shall be further enhanced with the incorporation of self contained smoke alarms in accordance with AS 3786. Smoke detectors must be installed in all occupancy units and be provided with battery back up and be hard wired.

3.2 Upgrade required exit doors in accordance with Clause D2.21 (c) or (d). (Refer Item 2.4).

Significantly, McCarthy considered that *'3.3 The recommendations made for this building should be taken as recommendations for all other buildings of the same occupancy.'*[21]

2.2.3 CONSULTANTS' SURVEYS AND THEIR USE

(1) INTRODUCTION

Throughout the years, there have been several consultants' reports on fire protection and related issues at KRS, undertaken at the request of the Department of Human Services, its predecessors or other government agencies.

Before considering the consultants' reports, it is useful to examine the fire risk management philosophy in a Health Department Victoria document entitled *'Draft Guideline for Fire Safety in Public Health Care Buildings – December 1990'*. Although only a draft (and applying to hospital-type environs), the document set out some fundamental guidelines in dealing with planning for fire

20 Exhibit 171 – Fire Report, pp. 1- 2 (4 pages).

21 Exhibit 171 – Fire Report, pp. 1-2.

safety where patients are involved. The Department's policy as defined in the Guideline was for new building work to be in accordance with the Building Code of Australia. The purpose of the document was to '*... effectively manage the risk to life and health from fire in health care buildings'*.[22] It stated that:

> *[f]ire safety in health-care buildings is important and there is a need to prioritise items so that available capital resources are used to best effect in safeguarding occupants. Health-care buildings are very different to other classes of buildings. Many areas are occupied 24 hours a day by staff trained in dealing with fire emergencies.*
>
> *Fire safety is the responsibility of the Agency. The Agency must promote awareness of fire safety issues through training, and the development of local fire safety policies and objectives. The* [aim] *of this guideline is to outline the fundamental considerations which will affect renovation works to existing buildings.*[23]

Factors that should be considered were: the nature of the occupancy; the type of building construction; the detection systems installed; the level of 'passive protection'; opportunities provided for evacuation to safe areas; and the size and planning of facilities.

However, the primary objective of the Guideline was to ensure patient safety, and to this end '*effective early detection and appropriate warning systems* [must] *be installed and that patient care areas and evacuation routes* [must] *be protected from fire so that structural integrity and fire separation are maintained long enough to permit progressive evacuation'*. Where 24 hour supervision is provided and '*automatic smoke detection and alarm systems'* are installed, the draft report does not call for the inclusion of sprinklers, especially in areas where smoke and fire compartmentation are provided.

Where alteration, renovation or additions are being undertaken special problems present in terms of fire safety:

> *The object of upgrading fire safety in existing buildings is to achieve an acceptable standard of fire safety for persons occupying that building. It may be impractical for technical or economic reasons to fully comply with current regulations or guidelines. When preparing a fire safety upgrading program the aim should be to priortise the desirable work on the basis of maximum risk reduction per unit dollar.*[24]

The priorities for resource allocation are: removal of obvious fire hazards; staff training; tenability of egress routes; smoke compartmentation; automatic smoke detection and alarm; hose reels; fire hydrants; automatic sprinklers; and fire resistance structure. In the planning process, the '*location of asbestos products which may be involved'* in the works would need to be identified. The report also discusses the application of the Building Code of Australia.

(2) TREASURY'S 'LUMLEY – RISK MANAGEMENT SURVEY'

In July 1992, Steeves Lumley Ltd was commissioned by the Department of the Treasury to conduct a '*risk management survey ... as part of the State Government's insurance program'* and was to advise on '*control measures designed to eliminate or minimise risk to persons, assets and resources'* with a goal of having '*risk management skills and techniques integrated into the client's normal day-to-day operations'*. The report prepared was the'Risk Management Survey'.[25] It is understood that, during 1992/93, this type of report was undertaken across government buildings as part of a commendable program to identify and reduce risk.

22 Exhibit 163.

23 Exhibit 163.

24 Exhibit 163.

25 Exhibit 53 – Lumley Report.

A rider to the Lumley Report notes that it *'does not imply that no other risk exposures exist to those mentioned ...'* and the *'recommendations do not claim to be all embracing. Nor do they indicate that alternate measures are not available or cannot be used to achieve the desired result'*. Futher, it is stated that the report was based *'on the information provided and conditions observed at the time the survey was conducted'*. To minimise interruptions to operations, a random sample of similar occupancies was inspected for compilation of the report.

In the context of what was eventually to happen at KRS, Lumley makes a telling point:

> *Subsequent changes may occur,* [which] *can therefore substantially alter the nature or degree of exposure of a risk and as a consequence, thereby invalidate the present control recommendations. These factors must be considered when corrective action is being planned towards implementing our advisory recommendations.*

The 'summary' in the report commented that *'several of the risk exposures'* were either *'similar in a number of occupancies, or, presented a potential for major loss, or, can be applied universally within similar centres'*, and the recommendations were designed to *'support several commendable initiatives already introduced'* at KRS.

In the general safety area, the report recommended the introduction of a 'Safety Tag Procedure' in the engineering/maintenance department and that safety audits be conducted on a bi-monthly basis. In the fire safety area, the report comments that it is *'[t]o assist with the introduction and maintenance of minimum standards for life and property protection throughout the Centre a number of observations and recommendations are presented relative to the various types of fire detection/ suppression equipment and management control measures considered warranted'*.[26] The Lumley Report identified that *'[s]ystems incorporating thermal detectors and a direct brigade alarm are installed in most occupancies with major control panels located at the administrative office'*. The report also notes that detectors were not installed in all areas and comments *'that systems are only tested monthly under contract and that tests are not being monitored'*. Australian Standards AS 1670 (Design and Installation of Automatic Fire Detection Systems) and AS 1851 (Testing Guidelines for Installed Systems) are referred to in the report. For fire detection systems Lumley recommends:

> *2.1.1 Review installation of fire detection systems to ensure efficiency of life and property protection and also, compliance with statutory requirements.*
>
> *2.1.2 Review specifications of service contract to ensure compliance with provisions of AS 1851.8.*
>
> *2.1.3 Centre officer to receive appropriate training to conduct weekly tests on randomly selected circuits of each system to record results of each weekly test and to also monitor tests conducted by contractor to ensure compliance with contract and that any discovered faults are immediately rectified.*[27]

Lumley critically commented on the lack of records for testing of the break-glass alarm points and recommended contact with the fire brigade for testing.[28] The report also commented on potential difficulties with the fire hydrants, water supply, hose reels and portable fire extinguishers. Recommendations were made on these issues.[29]

26 Exhibit 53 – Lumley Report, p. 14.

27 Exhibit 53 – Lumley Report, p. 15.

28 Exhibit 53 – Lumley Report, p. 14, para. 22.1; see also p. 15.

29 Exhibit 53 – Lumley Report, paras. 2.3-2. 5; see also pp. 16, 17, 18.

On a positive note, Lumley said of 'Fire Fighting Training':

> *Our survey disclosed the following commendable risk control measures:*
>
> - *Documented and distributed Fire Manual.*
> - *Fire committee formed to advise on protection and policy aspects.*
> - *Training sessions in the use of fire extinguishers conducted four (4) times per year.*[30]

In order to complement the measures recommended, the report suggested that:

> *2.6.1 Fire Manual ... be expanded and updated ...*
>
> *2.6.2 Fire fighting training sessions ... continue but include the use of fire hose reels.*
>
> *2.6.3 Serious consideration be given to the formation of a 'fire response team' who are trained in the suppression of fires, using all installed equipment, until the arrival of the fire brigade.*[31]

The report also commented and made recommendations on four 'Special fire risk exposures'; fire separation/smoke control management; fire brigade access and locks; dangerous goods; smoking policy; portable radiators and fire risk; hot work permits; housekeeping; emergency planning and procedures; emergency evacuation drills; emergency lighting; electrical safety; and keying alike system (for MFB doors).[32]

Under a section entitled 'Hazard Survey', Lumley documents a wide range of housekeeping and safety problems at KRS with many comments relating to fire.[33] On the 'Smoking Policy', Lumley comments that a '*Policy has been introduced which prohibits staff from smoking within buildings and vehicles and also clients from smoking in bedrooms and dormitories. We also noted the highlighted hazards on smoking presented on page 16 of the Fire Manual. While the advice not to throw cigarette ends into waste paper baskets is commended, we suggest more practicable solutions are warranted*'.[34] The recommendation was:

> *[i]n areas where clients/staff are permitted to smoke, we suggest that receptacles which separate combustible waste and cigarette ends and have a self extinguishing capacity be supplied.*[35]

A significant recommendation under the heading 'Emergency Procedures' was for '*[t]he provision of a local alarm within each building for emergencies other than fire ... . Measures such as an installed electrical alarm bell, portable hand held and operated siren'*.[36] It is noted that this recommendation does not comment on the lack of local alarms in some units for fire situations.

A comment under 'Emergency Evacuation Drills' draws attention to the fact that *'staff to client ratios during night shift varied from 1-8 to 1-30 and that night staff were required to conduct half hourly rounds. Should an emergency arise coupled with a power failure at night, we question the effectiveness of an evacuation from the larger and multi storey units such as Unit No's 1, 7 & 8'*.[37] The recommendations include:

30 Exhibit 53 – Lumley Report, pp. 18-19, para. 2.6.

31 Exhibit 53 – Lumley Report, p. 19.

32 Exhibit 53 – Lumley Report, pp. 19-30 (generally).

33 Exhibit 53 – Lumley Report, pp. 31-50 (generally).

34 Exhibit 53 – Lumley Report, p. 21, para. 2.11.

35 Exhibit 53 – Lumley, p. 21, para. 2.11.1.

36 Exhibit 53 – Lumley Report, p. 24, para. 3.1.3.

37 Exhibit 53 – Lumley Report, p. 25, para. 3.2.

3.2.1 Evacuation drills to be conducted on a planned regular basis so that effectiveness can be monitored and where applicable procedures improved and updated.

3.2.2 At least one evacuation drill per year for each unit should be conducted at night.

3.2.3 Evacuation drill requirements to be considered during the establishment of night shift rosters.[38]

On the issue of 'Emergency Lighting', Lumley commented '*not all units have an installed emergency lighting system'* and where installed are *'not subjected to regular testing and maintenance is carried out on a reported breakdown basis only'*.[39] Recommendations were made regarding installation and maintenance referring to Australian Standard AS 2293.

It is noted that the Lumley Report did not discuss the issue of sprinkler systems nor did it highlight the use of smoke detectors in bedrooms, although it did refer to AS 1670 which deals with smoke detectors. Further, under its detailed 'Hazard Survey Report', the comment on Unit 26/27 that '*[t]hermal detectors for automatic fire detection and alarm system are of old technology and are not installed in all areas of the occupancy. Possible delays in fire detection'*[40] may, with knowledge, point to the need for smoke detectors.

About the time the Lumley Report was delivered – July 1992 – sprinklers and smoke detectors were already being recommended by coroners in special accommodation residential care situations. The fire brigade had been making similar comments for some years.

(3) BSA'S 'DIBBEN' REPORT

In early 1993, a fire safety audit of KRS was commissioned by the Department of Human Services from the Department of Planning and Development (now known as the Building Services Agency). The report – '*Kew Training Centre Emergency Service Review'*[41] – was undertaken by consultants Mr Norm Winn and Corporate Emergency Planning Pty Ltd. Mr John Dibben, a civil, property and fire engineer from Planning and Development, provided his expertise and oversaw the report (called the 'Dibben Report'). Dibben, with Norm Winn, also undertook fire audits into a number of other institutions under the control of the Department of Human Services.[42]

The report's objectives were referred to in the 'Executive Summary' in the following terms:

The scope of this review involves the assessment of the existing emergency infrastructure at this Centre, the risk to the life safety of client residents and support staff and identification of measures and works recommended to be completed to provide an environment which minimises the risk to resident clients in an emergency.

The Kew Training Centre provides residential accommodation for 662 intellectually disabled clients. The Department has a duty of care to ensure that the risk to client life safety in an emergency environment is minimised. It is therefore considered essential that the Centre management and physical emergency infrastructure is in place and is able to operate effectively under emergency conditions.[43]

Dibben considered that the scope of the works in the report was in accordance with the '*Departments' philosophy of early detection, early warning, evacuation and suppression'*.

38 Exhibit 53 – Lumley Report, p. 25.

39 Exhibit 53 – Lumley Report, p. 25, para. 3.3.

40 Exhibit 53 – Lumley Report, p. 40.

41 Exhibit 54 – Dibben Report.

42 Janfield, Sandhurst, Pleasant Creek, Colanda and Turana Youth Training Centre (note: Corporate Emergency Planning were also involved in the audit for Turana).

43 Exhibit 54 – Dibben Report.

The Dibben Report deals with a wide range of fire safety deficiencies at KRS. Significant comments are made on fire safety in the 'Executive Summary'. The report also provides details of the cost of the measures recommended. In a telling comment, Dibben warns that *'[t]he greatest exposure of the Department to an emergency is during the after hour periods where 40 direct care staff only are on duty'*. Under the heading 'Evacuation and Emergency Procedures', Dibben remarks:

> *if a fire occurs out of hours, the high probability of rapid fire extension in most buildings will cause a grave situation. This will be exacerbated by the low staff levels and time and space (distance people need to travel to the scene).*[44]

Dibben considered that the first priority of the work is '*for the focus on the existing emergency management infrastructure to be expanded and upgraded to include establishment of a formal emergency management structure, revision and re-presentation of the existing emergency manual ...*'. Hand-held radios and a pager system are also suggested, and the report points to the fact that these are *'low cost, easy to implement'* and should be done ahead of other physical works. The physical works are considered to be necessary '*to minimise the client life risk in an emergency environment'*. Significantly, the report regards the works as a *'package which will collectively provide an environment where client life safety and Departmental exposure are minimised'*.

The Dibben Report considered that the early detection service should be revised and upgraded as it '*is aged, has detectors which are inappropriate and is linked to two separate fire indicator panels'*. Emergency lighting should be installed in units where lighting was not already installed. This would facilitate evacuation during an emergency when there is a power failure. The report also suggested replacement of the fire and domestic water supply as the existing service was '*old, prone to failure and beyond reasonable repair and is considered unreliable in an emergency'*. Examples of the problems identified were: four failures of the water main occurred in the month before the report; accurate plans of the fire main and isolation valves were unavailable; there was no booster connection for the fire brigade; and no key available for the pump assembly. The comment was made that:

> *[i]n the event of a fire, small or large, water is the basic ammunition for extinguishment. Therefore, it is essential that reliable fire mains are provided. It is critical [that] main replacement receives high priority.*[45]

Dibben recommends the installation of residential sprinklers which can *'provide almost 100% guarantee for client safety in addition to building fabric preservation'*. The report also recommends that a 'smoke extraction' system be considered, and 'smoke and fire compartmentalisation' of dormitory buildings be undertaken. It is noted that as the combined cost of smoke venting and compartmentalisation exceeds the cost of sprinklers it would not be required if the latter solution was adopted. Dibben comments on additional housekeeping such as '*progressive replacement of internal furniture and fittings'*, replacement of fire extinguishers and the preparation of a dangerous goods inventory.

In the detail Dibben examines staffing and comments on resident mobility; suggests a pragmatic approach to people safety (but to conform to Building Code of Australia (BCA) objectives at most times); and recommends that a '*door lock strike system ... be installed to the same specifications as other institutions'*. Further, the report recommends installation of 'mimic' fire alarm panels in all units (installed in some units) because:

> *[t]he purpose of these panels is to inform staff immediately, at a glance, of the alarm area. The staff are accountable for and have command authority of their building.*

44 Exhibit 54 – Dibben Report, p. 6.

45 Exhibit 54 – Dibben Report, p. 7.

Therefore, particularly at night – minimal staff of one (1) in most buildings, they can identify the problem area quickly. Otherwise, they are oblivious of the problem location until a call comes from the control centre.[46]

An early warning system should be strategically located in all buildings to warn staff and:

[i]t was found that if a warning device was installed locally at the building of alarm, it was inappropriately located. Staff could not hear it if and when it sounded. When alarms are installed, they should be tested weekly.[47]

Building structure is considered, and it is commented that '*many buildings have two separate units ... although efficient operationally, this creates massive conflict and problems from a fire safety point of view'*. Most sleeping areas accommodate 20 or more people with '*no fire (or smoke) separation within the sleeping areas'* and:

[n]o fire separation, ground level or roof void, exists between units in any single building. This is contrary to sound accepted practice and well outside any objectives of the BCA.[48]

Of Building 3, Dibben comments that it:

is the only building that meets BCA requirements. This building has been gutted and rebuilt to acceptable standards of separation between rooms and occupancies, has an appropriate detection system and alarm system. Fire extinguishers and hose reels provide reasonable cover if someone is available to fight a fire ... [49]

Dibben recommends replacement of thermal detectors with smoke detectors in accordance with the BCA and Australian Standards. On the detection system, the report specifically that it has '*grown like topsy, with no plans, no integration, no central control or communication system using old and new technology'*. It points to the mixture of part thermal part smoke detection systems '*connected by old technology wiring (which) is cause for concern. There is no doubt that this is a contributing factor to the high incidents of false alarms. Good maintenance would assist to minimise such occurrence'*.

On the issue of training, the Dibben Report is critical. After referring to the fact that some ad hoc training is undertaken by the MFB and evacuation training is conducted locally, the report comments that '*analysis of the records ... highlights inadequacies providing remedial action'*. The detailed examples are:

- *Disorganised (Staff)*
- *Poor Co-ordination*
- *Doors difficult to open (some keys unavailable)*
- *Poor procedures*
- *Some client resistance.*

In yet another telling remark, the report states that a major factor for safety *'is the time taken to evacuate the building. Five (5) minutes at the very minimum should be the standard. Barely half of the forty evacuations timed, were within this limit. The longest was 13 minutes – most would be dead. General average is 9 minutes. This requires improvement'*.[50]

46 Exhibit 54 – Dibben Report, p. 5.

47 Exhibit 54 – Dibben Report, p. 5.

48 Exhibit 54 – Dibben Report, p. 4.

49 Exhibit 54 – Dibben Report, p. 4.

50 Exhibit 54 – Dibben Report, p. 8.

To underpin the report. Dibben undertook a detailed 'Assessment' and made specific recommendations in several fire safety areas, such as exit signage; emergency lighting; inground fire mains; hydrants; hose reels; extinguishers; automatic detection systems; break-glass alarms; communication emergency warning and intercommunications system; DISPLAN; centre emergency management structure; evacuation procedure; implementation strategy; key system; bedroom furniture, fittings and housekeeping; emergency torches; equipment maintenance; and hazardous materials.[51] From the detail in the 'Assessment', the following comments are useful in relation to relevant systems problems still evident on 8 April 1996 (although the upgrade was addressing some of the problems):

> <u>*Exit signage*</u>
> *No formal maintenance plan Recommendations made.*
>
> <u>*Emergency lighting*</u>
> *Maintenance plan as per 'Exit signage'*
>
> <u>*Automatic Detection System*</u>
> *... inappropriate mix of thermal and smoke detectors ... particularly in dormitory areas.*
>
> *The false alarm rate throughout the complex is extremely high ...*
>
> *The whole wiring system should be tested and results recorded building by building. This will determine the validity of wiring and establish offending circuits. Faulty circuits can then be replaced.*
>
> *Recommendation: ... Overall strategy plan to upgrade the automatic alarm system; Train staff to test detector heads as per AS 1851; Treating all wiring unit by unit and replace offending circuits; Installation of smoke detectors in all sleeping areas; Ensure warning signals are installed to alert staff and building occupants ...*
>
> <u>*Emergency Procedures*</u>
> *DISPLAN – No plan has been developed for this vital area.*
>
> *Centre Emergency Management Structure: ... (On fire) There is no formal organisation; A fire committee is also established; No senior management appointments have been made to cope with the media, relatives or recovery; No formal 'team' response organisation or Control Centre. Recommendation: Emergency Manual (including emergencies other than fire); Formal coordinated emergency control organisation.*
>
> <u>*Bedroom Furniture, Fittings and Housekeeping*</u>
> *In order to minimise the fuel source of any fire which might occur in a client bedroom the existing furniture and fittings should be replaced with non-combustible or fire retardant, treated fittings. This item is not a high priority and proposed as a matter of good housekeeping and could be undertaken progressively as fittings are damaged or worn out and required to be replaced.* [Recommendations were made dealing with this issue.]
>
> <u>*Equipment Maintenance*</u>
>
> [On the service agreements with National & Fire Security, Jonkar and MFB Dibben comments that] *there is no doubt these organisations are performing to an acceptable standard. However, this does not abdicate management from the responsibility of conducting periodic spot checks. Such action ensures the contract dollar is being well spent.*

51 See Exhibit 54 – Dibben Report, pp. 9-15 (generally).

[The report suggests that] ... *considerable cost savings can be achieved by staff conducting some regular maintenance checks. Tests considered appropriate for this approach are: Exit lights; Thermal and smoke detectors; evacuation warning system ...*

Recommendations:

1. That a spot check requirement be allocated to a responsible person and the checks be recorded and on file.

2.Ensure that all work conducted under contract meets the relevant Australian Standard ...

4. Train staff to conduct maintenance of exit signs, emergency lighting, thermal and smoke detector heads.[52]

The Dibben Report also provides an 'Implementation Strategy' which sets priorities for the work. A '9' point plan is suggested. In the introduction to that strategy, Dibben again highlights the fact that *'H & CS has a duty of care to its clients and in recognising this duty all installations and planning must have in on* [sic] *the most vulnerable period for clients. This time is undisputedly outside normal daylight hours when on site staff is reduced as informed, only to 40'*.[53] The report also recognises that:

[c]onsiderable effort has been made locally to fund upgrading of existing buildings. This is commendable and many cost effective initiatives have resulted in much improved facilities.

However, it is imperative, funds available for local maintenance programs are spent to achieve and end result in concert with the suggested plans. In the past, large sums have been spent on a smoke detector program. This type of initiative must fall in with the standards and the overall plan.[54]

It is significant that Dibben also commented on staff housekeeping. The report said that *'staff are to be complimented on the general countenance of the establishment throughout. It is obvious considerable pride is taken in the area of responsibility of each individual. Such attitudes maintain a pleasant place to be and certainly minimise the risk of fire and its rapid spread'*.

When completed, in August 1993, the report was forwarded to Mr Bradley Edgar, Project Officer, DHS. Following delivery of the report, Dibben received no feedback on the comments and recommendations. Apparently, it was not forwarded by the Department to management at KRS. Mr Dibben was of the view that *'it certainly would be useful'* for KRS to have the report to look at their management practices.[55]

The immediate importance of the report can be seen from Mr Dibben's evidence:

Question: How important do you see the corporate infrastructure as compared with the installation of sprinkler systems and the like?

Answer: I think it's indicated there that we're looking on a holistic basis, and you need to look at all the different aspects there in terms of meshing and actually being supportive of each other. So in terms of the banking (sic – ranking?) we've looked at the emergency infrastructure there as something that can be relatively easy to implement. We would

52 Exhibit 54 – Dibben Report, pp. 9-15 (generally).

53 Exhibit 54 – Dibben Report, pp. 16-17.

54 Exhibit 54 – Dibben Report, pp. 16-17.

55 Transcript, p. 2843.

have a relative immediate benefit and while more cost intensive works might take a while to take their time to design – investigate, design and actually build – this is something that could actually be started straight away and you would get an immediate benefit and return.[56]

At the closing stages of the inquiry, a supplementary statement was presented by Counsel for the State of Victoria. In that statement Mr Dibben remarked that the purpose of the recommendation that '*staff be trained to conduct maintenance of exit signs, ... thermal and smoke detector heads'* was to involve them so that they '*would develop a degree of empathy for the system'*. He did not consider that staff would have the necessary skill and expertise to check the system beyond '*checking the Fire Indicator Panel for any sign of faults in the thermal or smoke detectors ...* [and] *testing the AIU connection to the MFB'*. It was not Dibben's intention that '*staff at KRS undertake any of the maintenance contractor's tasks or the functions of the Department of Planning and Development in ensuring that the maintenance contractor discharged its duties'*.[57]

It is noted that this issue has apparently not been put to Messrs Winn and Newton – the effective authors of the report – as their statements came to the court's attention after close of evidence. An examination of Mr Winn's statement and attached documents indicates that the body of the Dibben Report lifted Winn's draft recommendations for '*Equipment Maintenance'* using the exact wording. Thus, it would appear that Mr Winn is the person to whom the query should be directed and not necessarily Mr Dibben. This issue will remain an unanswered question in the inquest. It remains of concern that the Winn/Newton statements were not provided to the inquest prior to the close of evidence. This potential conflict is but one of the reasons underlying the importance of these statements and documents.

Dibben's supplementary statement also points to the fact that he considered that maintenance at KRS was being overseen by DPD:

4. I understood that the fire protection system at KRS was being maintained by a properly qualified contractor and that the Department of Planning and Development was responsible for the due performance of the contract. It was not my intent to recommend that staff at KRS undertake any of the maintenance contractor's tasks or the functions of the Department of Planning and Development in ensuring that the maintenance contractor discharged its duties.[58]

The Dibben Report is significant in that, for the first time, an internal departmental document draws together many of the problems and solutions posed in countless MFB reports, an insurance risk report (the Lumley Report) and comments by management concerned with fire safety at KRS. It is telling that Dibben found that many of the issues raised in those reports were still to be addressed.

(4) RESPONSES TO THE 'DIBBEN' REPORT

Unfortunately, the Dibben Report, which remained in final draft form, went no further than to sit in the offices of the Capital Management Branch (CMB) at DHS. It was not shown to KRS, which needed it most. Officers at KRS, who assisted the Dibben team with advice and inspection of the facility, requested a copy of the report – all to no avail. Neither Umow Lai & Associates Pty Ltd (ULA) nor Scientific Services Laboratory (SSL) saw the report. ULA and SSL prepared a later fire audit.

56 Transcript, p. 2874.

57 Exhibit 296.

58 Exhibit 296.

One of the reasons why the Dibben Report was not distributed was explained by Mr Savona of CMB in evidence:

> *Mr Hennessy: What is the position that whatever Dibben said about the management or procedural sides in recommendations he would make, or observations he would make, that would not be distributed because they had already been addressed by Lumley?*
>
> *Answer: Most of what was said in the Dibben Report had already been stated in the Lumley Report. It was almost a reiteration of the same report.*
>
> *Question: Didn't you think that of itself, if it repeated the same matters, that of itself was a compelling reason to re-distribute it and say in effect, "here's another consultant coming along and telling you the same things you've been told before. Pull your socks up" words to that effect. Didn't the fact that an independent and further consultant had made something similar observations and recommendations, didn't that of itself provide a compelling reason to again distribute that further report?*
>
> *Answer: The Dibben Report followed the Lumley Report. I believe the Lumley Report may have followed, and I can't be sure, but I've looked at other reports of a similar nature, probably fire brigade reports that have probably been there a number of years, and would have, I would suggest, addressed similar or the same issues.*
>
> *Coroner: You see, Mr Savona, there are things in the Dibben Report that might have been capable of being fixed immediately that may have had an effect on the process of the fire on 8 April 1996. It may not have resolved the fire problem completely but it may/ have had an effect. There's a number of issues. It's a simple management tool. You've got the report; you give it to the right people; you tell them they're repeating the same lessons, the same issues, the same messages from the Lumley Report and previous reports – what's being done to fix it. We understand the technical difficulties. Unless the people at Kew know these issues and know that it's – and the people in charge of managing Kew know that there are these holes that are still not fixed, how can they he expected to address the issues? Isn't that reasonable management?*
>
> *Answer: Your Worship, I would suggest that it would be very evident to them that the holes still existed or the work hadn't been done if they picked up the Lumley Report and went through it to see what hadn't been done, and I'm not sure if another report was necessary for them to do ... .*[59]

A comparison of the Lumley and Dibben reports reveals the latter to differ in significant ways. Dibben recommended sprinklers, Lumley did not. Dibben emphasised the need for smoke detectors in bedrooms. In Lumley, the issue of smoke detectors in bedrooms did not stand out as a problem, although alluded to in the report. In addition Savona commented that: '*[a]t a meeting that we had, basically my recommendation as regards the technical aspects of it was that they were flawed and the decision was made at that meeting that it shouldn't be released. The issues were that it created a lot of false expectations as well within report'*.[60] Further, although its distribution was not Savona's decision (evidently it was made by an Assistant Director),[61] Savona made the point that he:

> *saw there were flaws within the report, I also saw the report didn't provide the information required to go into the next stage for the project. The report was misleading in particular area.*[62]

59 Transcript, p. 6607.

60 Transcript, p. 6557.

61 Mr Barry Paice.

62 Transcript, p. 6606.

Following Dibben, Mr Edgar of CMB did not believe '*there was a perception of enormous risk*'.[63] He also considered that it was the view of CMB that the recommendations of:

> *the report could not be implemented in their existing form, and ought not to be released to field in their existing form, and that the technical recommendations in the report were compromised by the fact that Mr Dibben was not a qualified fire engineer.*[64]

Again, the point was made, this time in evidence:

> *Mr Hennessy: ... [T]he Dibben report, as far as you are concerned, had two problems. In so far as it dealt with the mechanical recommendations, it was flawed because Mr Dibben did not have sufficient expertise, and in so far as it dealt with management or procedural matters, it was redundant in the sense that those matters had already been dealt with in the Lumley Report?*
>
> *Answer: That was our view.*[65]

Mr Edgar agreed that the difference between the ULA Report and Dibben was that a person with the appropriate expertise had been briefed.[66] But when questioned further, it was stated:

> *Coroner: But even if you look at his report, irrespective of whether the event occurred or not, the very nature of his report pulling together the management issues and the engineering issues, taking a holistic approach, he has effectively got it right?*
>
> *Answer: That was the brief I gave him, Your Worship. That was the objective I hoped to obtain.*[67]

Further, it was said that:

> *[t]he fact that Mr Dibben made comment about management issues was very, very important. The fact that Mr Dibben made technical comments about particular items to install in terms of upgrading systems appear to be technically flawed.*[68]

It was also explained by Mr Savona that, because the procedures necessitated CMB obtaining a more detailed audit, the recommendations in Dibben were not acted upon.

Mr Savona, who had qualifications in building surveying and was an engineer, was on the Project Control Group (PCG) for the upgrade at KRS in the role of Assistant Project Manager. He recommended to management at CMB that Dibben was technically flawed. He had read Dibben in August/September 1993.[69] At the inquest, when questioned on the need for interim solutions to management issues, he stated:

> *Mr Hennessy: You see, Mr Savona, apart from the technical matters which you might say have got some flaws or some problems with them, Mr Dibben clearly said that if a fire happens at night with the limited staff on at night, predictably there'd be evacuation problems. He says that, doesn't he?*
>
> *Answer: Yes.*

63 Transcript, p. 6239.

64 Transcript, p. 6210.

65 Transcript, p. 6258.

66 Transcript, p. 6259.

67 Transcript, p. 6260.

68 Transcript, p. 6260.

69 Transcript, p. 6551.

Question: Now, that's something that, with the benefit of hindsight at least, you'd say should have been thumped into the management at Kew? Somebody should have been screaming about that? 'Mr Dibben says this; think about it. It might mean extra people night; it might mean a patrols; it might mean any number of things at night.' But it might call for a non-hardware response, mightn't it ?

Answer: That same issue was raised in Umow Lai report as well.

Question: Okay – a year later? – It was before the fire it still could have been acted upon.[70]

Apparently, Mr Savona, who had the additional knowledge of what was in the Dibben Report and qualifications in building surveying and engineering, did not consider other management alternatives when the interim hardware solutions were not accepted. Clearly, at the time Dibben was in the hands of CMB, many of the problems identified in the Lumley Report had not been addressed. That position continued through to the ULA Report and beyond.

The decision not to distribute Dibben is even more troubling when, following separate representation of BSA after the close of evidence, two statements prepared in late February 1997 were forwarded to the Coroner by solicitors for that agency. The statements were from Messrs Norman Winn and Ronald Newton. Both men are safety experts. Winn's expertise is fire while Newton's is in emergency response. Both experts were the effective authors of the Dibben Report. Neither was given any feedback on the fate of the report.

Mr Winn's statement shows that at least part of the argument put forward by both Savona and Edgar does not stand up to examination. It establishes his broad expertise and experience in the fire safety industry. In addition to fire safety expertise, Winn has special qualifications to deal with the KRS issue:

During the period 1967 to 1975 I was a member of the Board of Management of Alexander Home and Hospital for the Aged in Castlemaine. In that role I became familiar with the relationships between staff, clients and their families, and the emergency response difficulties associated with non ambulatory and disabled patients.[71]

On Mr John Dibben's approach, Winn writes that:

[w]e were informed by John Dibben that we could exercise our professional judgment and approach the report in the manner we considered to be appropriate. John Dibben wished to achieve a completely independent and comprehensive review of the existing system at Kew and a proposal for complete emergency response. There was no formal or specific written brief. Unlike most contracts, we were not encumbered by restrictions. This was a most helpful approach.[72]

In preparing the report, Winn received '*excellent cooperation and support'* from Taylor, Vasan and supervisory staff. On Vasan's involvement, he stated:

I particularly found Srini Vasan to appreciate that there were deficiencies in the quality of procedures and some equipment and documentation, and found him anxious that improvements be made at Kew. Srini Vasan specifically expressed his concerns about staffing levels at night and that this together with their lack of training would provide difficulty in effecting evacuation of residents in an emergency.[73]

70 Transcript, p. 6612.

71 Exhibit 299 – Mr Winn's statement, para. 2.

72 Exhibit 299 – Mr Winn's statement, para. 3.

73 Exhibit 299 – Mr Winn's statement, para. 11.

On the report itself, Winn commented to the effect that after submitting his draft nothing happened. He spoke with Mr John Dibben who confirmed it had been submitted to the Department of Health and Community Services. A few months later he again spoke with Dibben *'to enquire about the progress of a response to the report'*. At this time Dibben was not aware of its progress. Winn had no further contact relating to the fire safety issues at KRS.

On viewing the report before the inquest, Winn stated that an 'Executive Summary' had been added. Of Dibben's Executive Summary, he stated that he considered it:

> *accurately reflects the content and impact of the report, although I would have been more forceful in comments requiring immediate senior departmental response by what was then the Department of Health and Community Services. Those forceful comments do however remain in the body of the report.*[74]

Mr Newton read Winn's statement and confirmed many of its comments. He also agreed with the remark on the Executive Summary.

The Parents' Association Submission comments that the '*ultimate explanation given for failing to provide the Dibben Report to KRS is that it was perceived as not raising anything that had not been raised in the prior Lumley Report. This is factually incorrect, Dibben did make new observations; but in any event, it is an inherently unsatisfactory reason. If Dibben showed matters addressed by Lumley continued to be a problem, then this is all the more reason why Dibben should have been given to KRS'*.[75]

In its submission, the BSA deals with many of the points already discussed, including the qualifications of Messrs Dibben, Winn and Newton, and says that '*the Dibben Report was not technically flawed as having an inappropriate focus on the BCA (Building Code of Australia). Any focus on the BCA was appropriate as the BCA provides guidelines for such review'*.[76] In addition, the BSA states that the *'Dibben Report speaks for itself ...*' and that it '*provided what FAS (sic 'KRS') asked for from BSA*'. The BSA Submission points to the fact that there '*was no formal or specific written brief ... This goes to show further that the response of BSA to the request for the provision of a report by CSV was not specifically required to be in a particular style or form'*.[77]

It is, and always was, difficult to understand why the Dibben Report was not distributed. Dibben was not just another report to be shelved. Rather, it was a vital document in a chain of events and systems failures that inevitably led to the fire. Management failed to give it the airing, credence and urgency it properly deserved. It was both a management and technical tool that was not used to effect.

(5) UMOW LAI & ASSOCIATES PTY LTD

Following receipt of the Dibben Report, DHS contracted Umow Lai & Associates Pty Ltd (ULA)[78] to undertake a further fire safety audit of the buildings at KRS. That report was completed 12 months after Dibben, in August 1994. Scientific Services Laboratory (SSL) were engaged by ULA to undertake a building by building audit. A 'Project Team' comprising ULA (Fire Safety Engineers and specialists in building fire safety), SSL (Consulting Fire and Risk Engineers) and the Gardner Group (Consulting Building Surveyors) was engaged to examine the fire safety issues.

The 'Executive Summary' of the ULA Report repeats the concerns of Dibben when it states that *'the current level of fire safety is inadequate, due to:*

74 Exhibit 299 – Mr Winn's statement, para. 11.

75 Parents' Association Submission, p. 10, para. 26.

76 See generally BSA Submission, pp. 14-17, para. C.1.1; see also p. 16.

77 BSA Submission, p. 17, para. C.1.3.3.

78 Exhibit 143 – ULA R eport.

- *Inadequate levels and type of early warning fire detection provision*
- *Moderate to high fire loads in dormitory levels*
- *Existing fire service ring main is unreliable.*

ULA's concerns are clear: *'[b]ased on the fire risk assessment, a fire in a residential unit could develop to a point where untenable conditions exist prior to full evacuation of the affected area'*.

In the introduction to the report, ULA remarks that the Board of Management at KRS *'recognised that the present fire and life safety provision may not be of sufficient standard to provide a safe environment for the clients who live at or people who work at the Centre every day in the event of a fire occurring'*. The 'objective' of the upgrade has been identified by the Board of Management as *'bringing fire safety ... up to a reasonable level'* acceptable to the Centre, Department of Health and Community Services and the Building Surveyor. The report estimates that implementation of the works could occur over two to three years, and it establishes a priority for the work.

ULA (and the Project Team) was to *'identify the deficiencies ... which adversely affect the life safety of the occupants ... evaluate risks ... quantifying the hazards present (and) recommend the most effective measures to be adopted ... tailored to the Centres particular problems to provide a fully integrated fire and safety package'*.[79] The report noted that the consultant Building Surveyor *'has determined that the unit buildings are Class 9a (health care buildings) under definitions contained within the Building Code of Australia'*.[80]

In the report, ULA points to the fact that no fire separation exists between units in a common building.[81] Under 'Fire Safety Systems', the report comments on the detector issue:

> *Limited fire detection is provided. In many units there is a mix of heat and smoke detectors, with quite substantial number of areas having no detection at all. Where detectors are installed, many are old, discoloured and in need of replacement.*

On alarms, it is stated that *'[a] number of buildings have individual fire indicator panels that provide local alarms. However many buildings have no local alarms and must rely on telephone calls for alarm signalling from the administration building'*. On Exit signs, etc, it is commented that *'[e]xit signs and emergency lighting are provided in some buildings only'*. On emergency plans, the comment is made that *'[f]ormal emergency plans exist, with control under the direction of a supervisor. Staff in adjacent buildings are summoned to assist in evacuation and an extensive drill program was conducted for evacuations up until the last 6 to 12 months'*.[82]

A 'Fire Safety Audit' was conducted which identified a significant number of problems.[83] ULA made comments about the fact that regular fire drills are no longer performed and that some staff have no training. The report also makes the point that reducing numbers of staff lowers the probability of satisfactory staff response to an emergency.

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79 Exhibit 143 – ULA Report, p. 3.

80 Exhibit 143 – ULA Report, p. 4.

81 Exhibit 143 – ULA Report, p. 4.

82 See generally Exhibit 143 – ULA Report under 'Fire Safety Systems', p. 5.

83 Including (but not an exhaustive list) higher fire loads in the sleeping areas, particularly high combustible mattress, bedspreads, clothing baskets, cupboards etc in many buildings; limited cigarette smoking in some buildings and radiators/toasters but only in staffed areas; no automatic sprinklers; heat and some smoke detectors but many areas without detectors; exit and emergency signs not consistent and in some areas not provided at all; only limited number of buildings with fire indicator panels and local audible alarms; regular fire drills no longer performed and some staff with no training; reducing numbers of staff lowers the probability of satisfactory staff response to an emergency; no earth leakage protection on electrical power circuits: see generally the ULA Report under 'Fire Safety Audit', pp. 6-7.

A 'Quantitative Risk Assessment' using a fire engineering computer package (HAZARD 1) was undertaken. It presented the *'times for ignition, development of fire, spread of smoke, activation of smoke detectors, arrival of the fire brigade, and evacuation of the building have been estimated ... which diagrammatically show the occurrence of these events with time'*.[84] Inspection of the units indicated that the fire load varied between individual buildings as well as within buildings. Four fire scenarios were selected with various types of fires between medium, insipient/medium and fast.[85]

ULA also undertook a 'Qualitative Risk Assessment' based on numerical values for factors such as *'client mobility, building construction, fire separation and automatic detection systems'*. The method was called 'NFPA Life Safety Code 101M – Board and Care Facilities'. It was developed in the US for the type of facility. ULA considered that used *'with care, it can be a useful guide to fire safety in Australian facilities'*.[86] Following the NFPA analysis, ULA concluded that:

> *the current level of fire safety in the residential units at Kew Training Centre was unacceptable for all four risk categories of 'Fire Control', 'Egress Provided', 'Refuge Provided' and 'General Safety Provided'.*
>
> *Further analysis was performed to determine whether the level of fire safety would be considered acceptable for upgrades consisting of smoke detectors only, smoke vents only, automatic sprinklers only, smoke detectors and smoke vents and finally smoke detectors and automatic sprinklers.*
>
> *The analysis showed that the level of fire safety was improved with each of these upgrade measures, but only for the upgrade of smoke detectors and automatic sprinklers were the risk scores greater than the target scores. That is only for smoke detectors and automatic sprinklers was the level of fire safety considered acceptable for all four categories 'Fire Control', 'Egress Provided', 'Refuge Provided' and 'General Safety Provided'.*[87]

ULA's 'Evaluation of Analysis' suggested that the time lines indicated that the existing fire safety system provided sufficient warning for staff evacuation of occupants in all areas except for sleeping/ dormitory. In sleeping areas with high fire load, it is stated that:

> *limited fire detection and lack of local fire alarm warning within the units means these areas are a potential threat to the clients. Time line analysis for a sleeping area fire indicates that insufficient time will be available for the staff to evacuate the clients, even with earlier detection through the use of smoke detectors.*[88]

The evaluation concluded that an automatic sprinkler system was required and that experience *'in Australia has shown that the likelihood of fatalities in sprinkler protected building is substantially less than in non-sprinkler protected buildings'*.[89] By way of example ULA cites H. W. Marryatt's report *'that only 3 people have died, in residential and institutional type premises protected by automatic fire sprinklers'*.[90] After the fire, on 7 May 1996, Mr David Uhlhorn of ULA in a memorandum to Mr Lai wrote under the heading 'Findings':

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84 Exhibit 143 – ULA Report, pp. 8-16.

85 The detail of the methodology is found in pp. 8-10 of the ULA Report. For the tests, see pp. 11-15; for computer modelling results, see Appendix 111.

86 Exhibit 143 – ULA Report, p. 16.

87 Exhibit 143 – ULA Report, p. 16.

88 Exhibit 143 – ULA Report, p. 17.

89 Exhibit 143 – ULA Report, p. 17.

90 Marryat, H.W., *Fire – A Century of Automatic Sprinkler Protection in Australia and New Zealand 1886-1986*, Australian Fire Protection Association, 1988.

The major finding of the audit was that the residential buildings posed the greatest potential risk, specifically fires occurring in the dormitory/sleeping areas. The majority of the fire service upgrade works is directed at these buildings, with specific emphasis on the dormitory/sleeping areas.

Engineering analysis indicated that for fires occurring in areas other than the dormitory/ sleeping areas, the existing fire safety systems provide sufficient warning to allow staff to evacuate all the occupants.[91]

In its report ULA provided the following 'Additional Recommendations':

In addition to the capital works identified, the following is also recommended to improve the life safety of Kew Training Centre:

- *Reconvene the fire safety committee with clearly defined duties and responsibilities relating to the implementation and maintenance of fire safety systems and procedures.*
- *Ensure all staff receive regular (at least annual) training in emergency procedures and the use of first response fire equipment.*
- *Continue to implement and record regular emergency response drills, including trial evacuations both during the day and at night.*
- *Review the use of less flammable materials in future refurbishment projects. General guidance on reducing the fire hazard within buildings is given in Appendix X.*
- *Consider the use of evacuation sheets to aid in the evacuation of bed-ridden Clients.*[92]

At the inquest the 'Additional Recommendations' were considered by Mr Lai to be the 'interim' procedures to be adopted in addition to the capital works. Apparently, automatic door opening systems and the systems to manage any fire-lighting behaviour were not considered.

The 'Additional Recommendations' were not adopted at KRS before the fire.

In preparing the report, ULA was not provided with the earlier Dibben Report, which was not made available to Mr Lai until late December 1996 (and not read until the end of January 1997). The Department's 'Consultant Brief' stated that *'4.0 An emergency Services Review by the Department of Planning and Development for Kew Training Centre has been completed and will be available to the successful consultant'*. That document – Dibben – was not made available at the time of preparation or the managing of the upgrade following the 1994 fire audit (even though requested).

(6) SCOPE OF THE 1994 'AUDIT': THE ROLE OF ULA AND SSL

A 'FULL AUDIT'

The *'Kew Training Centre Fire Safety Upgrade – Consultant Brief, Fire Audit and Schematic Design'*, which was provided to prospective consultants in 1994, was designed to *'assist them in preparation of a submission for the project'*.[93] Thus, as a prospective consultant, ULA received a copy of this document. The objective of the project was to *'bring the Fire Safety level of Kew Training Centre up to a reasonable level that will be acceptable to the Training Centre, Department of Health and Community Services and the certifying Building Surveyor'*. The funds were to be used *'to the greatest effect with maximum efficiency in order to provide economically feasible solutions to quickly identity the early stages of an accidental fire and to provide the greatest fire risk reductions'*.[94]

91 Exhibit 162, pp. 50-52.

92 Exhibit 143 – ULA Report, p. 20.

93 Exhibit 162, para. 2.1.

94 Exhibit 162, para. 2.2.

The project was specified as being in two stages, the first being a '*full fire audit of existing buildings and services'*. The project's scope was to be determined after the fire audit. Stage two was the *'identification of best options* [for] *prioritising of works into urgent, high, medium and low priorities, the provision of a limit of cost budget and the schematic design of fire systems'*.[95] The upgrade was to include: a fire audit; appraisal of the Building Regulations in accordance with section 17 of the *Building Control Act*; identification of options for each building; evaluation and selection of the best option for each building; and schematic design.[96] The Principal Consultant had a responsibility to '*document a fire audit for all nominated buildings on site'*.[97] The project consultant was to be provided with the Dibben Report. It was stated that:

> *[a]n emergency Services Review by the Department of Planning and Development for Kew Training Centre has been completed and will be available to the successful consultant.*[98]

As has been revealed, this did not occur so a valuable source of material was lost.

There was no indication in the brief that the proposed 'fire audit' was to be anything less than a full audit. However, some clues to what was really intended may be found in the evidence of Mr Savona of CMB who prepared the consultant brief (and advised that the Dibben Report was technically flawed'). He said in evidence:

> *Question: In essence, to your understanding it was a full and comprehensive fire safety audit?*
>
> *Answer: Yes. I believe it did cover all the issues in regard to fire safety audits, and it provided sufficient detail.*
>
> *Question: You had experience in terms of audits in the past?*
>
> *Answer: Yes, I've done several – well I've been involved as a Project Manager in several of the audits in the past, other locations.*[99]

The ULA Submission suggests that Mr Savona's evidence is significant. He, it is said, '*had the experience and qualifications, drafted the brief, was a member of the interviewing panel and approval process and was involved in the project from its inception until May 1995, and was of the firm view that the audit was complete in all necessary detail and as to all issues'*.[100] Conversely, the State of Victoria argues that *'[t]he effect of Mr Savona's evidence is mis-stated by counsel for ULA at paragraph 3.39 of their submission. The substance of Mr Savona's evidence was that he believed that the report of ULA and SSL had covered all relevant issues. His evidence was, however, that he was not aware of the fact that ULA/SSL had not conducted a full and thorough fire safety audit. It was his expectation that they would do so and his assumption that they had done so'*.[101]

At this stage it is useful to digress to consider the distribution of the Dibben Report. It should be noted that Mr Savona considered that one of the reasons for not distributing Dibben was that it did not contain a thorough analysis of previous reports (Lumley/MFB).[102] Yet Dibben was not given to ULA. The difficulty for the 'full fire audit' argument can be seen in the following exchange:

95 Exhibit 162, para. 2.2.

96 Exhibit 162, para. 2.2.

97 Exhibit 162, para. 6.

98 Exhibit 162, para. 4.

99 Transcript, p. 6543.

100 ULA Submission, p. 28, para. 3.39.

101 State of Victoria Submission in Reply, p. 368, para. 2.14.

102 Transcript, p. 6625.

Question: On p.3 of his audit is where he identified, in recognition of the reality that the project team has been directed to and he lists three points; one is, which effectively says, he must identify any deficiency in the system whether it requires interim solution or whatever, that was part of his task and, indeed, Mr Johnson last week, accepted that that was the position as he understood it. Is that how you understood the function of ULA?

Answer: As expressed in his document, yes . They were to identify any of the fire safety issues that were relevant or that

Question: Be they technical, be they management, whatever; his job was to advise of any deficiencies that he perceived at Kew?

Answer: That is correct.

Question: And advise what to do about it?

Answer: Yes.

Question: Short term or long term; that was his function and he accepted it, as he obviously yes?

Answer: Correct.

Question; Then would you imagine that he would be able to pick up anything that any other previous report had done, being the expert in the field?

Answer: I would – yes, I would expect that he is giving us a full identification of what is there and what is proposed to be there and he should be able to provide all the issues that are relevant.

Coroner: But why shouldn't he see other reports; earlier reports why wouldn't you give him a complete file with fire reports, Lumley report, Dibben report; all that material to assist him to do his job better?

Answer: I didn't say I wouldn't. I expect that he would search that out and I would be more than happy to give it to them, and I would expect them to go looking for them. ...

Question: In your evidence in chief yesterday, you deposed that one of the functions, one of the requirements in preparing a comprehensive fire safety audit such as this, is to look at past, as well as present and future?

Answer: Yes, to provide the full picture it is important to look at the past.[103]

In this exchange Mr Savona opts for a full fire audit. Yet critical information in the possession of CMB has to be identified before it will be released to ULA. It is not a very helpful approach nor is it indicative of an intention to expand the work of the audit. At the close of his evidence Mr Savona remarked:

Question: ... [I]t still, I take it, does not change the evidence that you gave in evidence-in-chief yesterday that you were asked by Mr Olle to your understanding it was a full and comprehensive fire safety audit – he's referring to the ULA audit – and your reply was, "Yes, I believe it did cover all the issues in regard to fire safety audits and it provided sufficient detail". That remains your answer?

Answer: Yes.[104]

It must be remembered that Mr Savona had also read Dibben. It is reasonable to conclude that he knew of all the management issues raised in that shelved report. In the event that ULA did not cover the issues required in the audit, presumably the additional matters (such as maintenance)

103 Transcript, pp. 6628-6629.

104 Transcript, p. 6639.

referred to in Dibben should have been raised with the fire engineers. Mr Savona had qualifications in building surveying and engineering. It would not be unreasonable to conclude that he would be aware of the need for sound maintenance practices and compliance with Australian Standards. Mr Savona was also on the PCG.

ULA's report did not mention the 'maintenance compliance' in detail. It must be remembered that ULA did mention maintenance (under 'Additional Recommendations') to the effect that the Fire Safety Committee should be reconvened *'with clearly defined duties and responsibilities relating to the implementation and maintenance of fire safety systems and procedures'*. This was not done. It also points to an inappropriate mix of smoke and thermal detectors.

The State of Victoria submitted that ULA (and SSL) did not have a building by building approach. This would have *'more fully'* identified deficiencies in the system.[105] There is no doubt that a detailed building by building approach would have identified some of the hidden issues that are only just coming to light. In support, it was argued by the Parents Association that *'the report was lacking in sufficient depth and analysis'*. It is suggested that this may have contributed to DHS's ignorance of poor work practices at KRS. It is stated that ULA:

> *failed to ensure a proper condition audit of the existing system including auditing of maintenance of the existing system and advising KRS of all deficiencies found in this process. Although some breaches of good practice or Australian standards were pointed out in the Audit Report regarding the existing system, these were simply examples of deficiencies rather than being a thorough building by building audit identifying audit identifying all major deficiencies. ULA also did not test the operation of the existing system and did not identify to KRS the absence of "as installed" plans of the fire detection system in the fire indicator panel nor did they bring breaches of Australian standards by the maintenance contractor to the attention of KRS.*[106]

According to the Parents' Association, Mr Lai should not have accepted that SSL's limited audit met the requirements in the consultant's brief and that information *'as to the deficient spread of smoke detectors in buildings should have been specifically identified to KRS. Nevertheless, by the time of the upgrade being commenced KRS had renovated Unit 31, so the SSL survey would not have been reliable after the renovations'*.[107] The Parents' Association also suggests that there was evidence *'that KRS had no idea what the current state of the fire alarm system was throughout units at KRS.'* Examination of other material[108] tends to suggest that this submission is not correct.

A contrary view is put in the SSL Submission. It is suggested that management looked to the ULA Report (and not the attached SSL audit) for confirmation of that which was necessary. It is said that:

> *[t]he purpose of commissioning the ULA report was to obtain recommendations supported by a proper fire engineering analysis because the Dibben Report was seen as being "technically flawed". Not that its recommendations were inappropriate or its criticisms invalid, but flawed because Dibben was not sufficiently qualified as an engineer at the time (see Edgar 6195: 6198-9; 6211-6212). In other words if the recommendations were backed by an appropriate engineering analysis it was perceived by the people at Kew that Capital Management would make the necessary funds available. Edgar's evidence supports Johnson (@5698) that the audit was done to provide an engineering basis for ULA to put*

105 State of Victoria Submission, p. 20, para. 7.2.

106 Parents' Association Submission, p. 127, paras. 366-367.

107 Parents' Association Submission, pp. 127-128, para. 67.

108 Especially Exhibit 128 – the Fabric Survey.

together a program for major upgrade works. The history of the route to upgrade does not suggest in any way that Kew management was looking for a detailed specification of every fault in the system.[109]

However, it is important to remember that management at KRS already '*had a continuing lack ... of faith in the ageing system*'.[110] They were aware that smoke detectors were being changed for thermals. On this issue advice from fire engineers was not sought. The late-breaking statement of Mr Winn is also telling of management knowledge of deficiencies during 1993. Winn found that Mr Vasan appreciated that:

there were deficiencies in the quality of procedures and some equipment and documentation, and found him anxious that improvements be made at Kew. Srini Vasan specifically expressed his concerns about staffing levels at night and that this together with their lack of training would provide difficulty in effecting evacuation of residents in an emergency.[111]

Both Mr Vasan's knowledge of the issues and his work towards improved fire safety at KRS are confirmed in a memorandum to Savona on 21 January 1994 which states that:

[a]s our fire alarm system does not provide local warning and delays due to the extent of site/location of buildings and staff numbers in unit etc., replacement or modification to existing system has become our top priority.

I would prefer if safety audit could include to recommend an appropriate fire alarm system and auxiliary equipment so that Kew Management may invest towards them than upgrading the existing.

I have no further comments to add to the brief.

The experts, such as Inspector Martin, took the view that a full fire audit, in terms of industry practice, would:

touch on all matters relative to fire safety. It would look on the structure, the environment, the systems in place, those being fixed systems in terms of alarm systems, suppression systems, and include staff training manuals, those sorts of things, all aspects consistent with fire safety.[112]

In his report, Mr Daryl Knight said that:

[t]he overall object of any fire audit of existing buildings must be the identification of those matters which require attention in order to achieve a level of fire safety in buildings which ensures that people's lives are not put at risk. ... If it is determined that they are inadequate the question will arise as to whether interim measures are necessary before the finalisation of the fire risk audit. It is not uncommon that situations are identified which require immediate rectification for people's safety.[113]

If ULA was to conduct a 'full audit', it is clear that the document delivered to KRS by ULA in August 1994 did not comply.

109 SSL Submission, p. 21.

110 Evidence of Mr Taylor in Transcript, p. 5362.

111 Exhibit 299 – Mr Winn's statement, para. 11 (emphasis added).

112 Transcript, p. 6702.

113 Exhibit 212 – Mr Knight's Report, pp. 9-10.

About the time ULA was undertaking its work, a *'Fabric Survey & Building Utilisation Study'* for KRS was nearing completion. 'The Management & Staff Kew Cottages' and CMB were on the Project Team for that study, which, released in September 1994, just one month after ULA, notes the paucity of smoke detectors in Building 37. It also mentions noncompliance with the Building Code of Australia/Australian Standards throughout the complex.[114]

It is noted that the extensive submission (and Reply) of State of Victoria does not raise the Fabric Survey in connection with this issue. However, the survey is clearly relevant as it is a detailed and lengthy document which deals with fire safety issues throughout the body of the report. KRS management were involved on the Project Team for the Fabric Survey. Further, the State of Victoria's Submission does not adequately deal with the failure of management to address the relevant recommendations in the Lumley Report (or the Dibben Report) or the Fabric Survey. In addition, if 'a full audit' was being undertaken by ULA (and expected by CMB and/or KRS), the question arises why it was necessary to cover the 'fire' issue on a building by building basis in the Fabric Survey that was being conducted at the KRS complex about the same time.[115] It must be remembered that management at KRS and CMB were on the Client Project Team for this survey. This question remains unanswered, but it does result in some circumspection about the force of the argument that a full fire audit was always intended. It lends some support to SSL's submission.

The Fabric Survey also raises further questions about the extent of management's knowledge about the state of the fire safety system.

The issue of fees may provide some indication of the perceived extent of the original ULA audit. As pointed out in ULA's Submission:

> *[o]f the total fire safety consultancy fee of $18,800, $11,610 (61%) was paid to SSL, and $1,000 went to the Gardner Group. Of the total audit consultancy fee, ULA retained less than a third. The allocation of fee income provides an insight into the consultancy and audit process.*[116]

It would seem that a 'full audit', including tracing wiring and detailing each and every deficiency 'building by building', would be both a costly and time-consuming exercise. An indication of the extent of that exercise can be seen from the fact that there were 27 large residential units at KRS.

At the end of an examination of the argument for a full audit (as compared with that provided by ULA), the reader is still left with the strong impression that DHS management (KRS and/or CMB) were well aware of the issues and of the risks. Recently, advice had been received from Lumley, Dibben and the Fabric Survey on similar issues. It is abundantly clear that ULA was not the only repository of advice and knowledge on the inadequacies of the fire safety system. What can be said was effectively admitted by Mr Lai of ULA In summary, Mr Lai acknowledges the failure to draw attention to:

1. the maintenance of the detector system or circuitry;
2. the absence of circuit and detector plans;
3. the locked doors; and
4. fire-lighting risk.

114 See also discussion in the Findings in **2.2.3 (7) The Fabric Survey & Building Utilisation Study.**

115 ULA commenced its work in April 1994; the Fabric Survey building by building surveys were conducted in May 1994.

116 ULA Submission, p. 20, para. 3.7.

Mr Lai was always prepared to accept some degree of responsibility for the perceived shortcomings in the ULA Report. In that regard he was both an impressive and concerned witness.

The Villamanta Legal Service Submission summarises the issue on maintenance well:

> *The shortcoming of the Lai report with respect to maintenance is acknowledged by Mr Lai (3565). This relates to emphasis on non-compliance with Australian Standards and so advising Kew. If a condition report were completed it would have articulated the particular failings of each building to comply with Australian Standards. Whether any remedial action would have been taken is purely conjectural given the imminence of the final upgrade, the magnitude of the breaches and the cost of remedy. General observations were made about the failure of the existing system in the Lai report (#169 p. 6).*[117]

The submission suggests in respect to wiring:

> *The issue of wiring is more complex. The proposition that inspection of the wiring should have been part of the audit is not consistent with what is normal in audits. Mr Johnson's evidence that even in condition reports wiring is not necessarily examined. On the other hand the option to use existing wiring in the final upgrade presented in the Lai report suggests that some evaluation of the wiring should have been made before such an option was presented. VLS understands that the explanation of this lacuna lies in the nature of the new system which has the capacity to test and alert the Fire Indicator Panel when the circuit wiring is faulty. (VLS submits that when wiring is as old as that in Kew it should have been completely re-wired and understands that the use of existing wiring was driven by budget constraints.).*[118]

It should be noted that ULA raised concerns in its report about sleeping areas. Mr Lai articulated those concerns in evidence. He had informed KRS.

> *Mr Hicks: ... And in particular you had come to the conclusion that as far as the sleeping areas were concerned, your analysis had indicated there would be insufficient time to evacuate the clients?*
>
> *Answer: Yes.*
>
> *Question: We can conclude, can we not, Mr Lai, that at 24 August 1994, you were of the view that if a fire occurred at Kew Cottages in a sleeping area, it would amount to being a death trap?*
>
> *Answer: It's a very subjective term, but perhaps if I said that the risk in the dormitory and the sleeping area would be significantly higher than in other areas of the site.*
>
> *Question: Mr Lai you had come to the conclusion at 24 August 1994, that if a fire occurred in the sleeping areas of Kew Cottages it would be a death trap. There would be insufficient time to evacuate the clients, did you not?*
>
> *Answer: We established that there would be insufficient time for the clients to – yes.*
>
> *Question: Not only did you know that fact, but ~~ you communicated that fact to Kew Residential Services?*
>
> *Answer: Yes, we did.*
>
> *Question: So both parties were fully aware of that at 24 August?*
>
> *Answer: Yes. ...*

117 Villamanta Legal Service Submission, p. 25, para. 6.5.1.1.

118 Villamanta Legal Service Submission, p. 25, para. 6.5.1.1.

Question: As a result of discussions, no interim measures were put forward as far as capital works were concerned; is that correct or not?

Answer: No capital work interim measure were proposed.[119]

In conclusion, ULA admitted that it failed to draw sufficient attention to some specific management issues. Whether or not the audit was to be a 'full audit' is problematical. The parties to the audit may well have had a different understanding of what was required. Mr Lai's view was that the *'emphasis'* was on '*the urgent replacement'* of the existing system.[120] The view at KRS, as expressed by Taylor, the Facilities Manager, was for '*a comprehensive fire prevention audit to provide the basis upon which the fire safety system would be improved'*. Mr Vasan expected a full fire safety audit on everything.[121]

The end result is that the admitted problem for the ULA audit was with some of the detail rather than the broad conceptual document. Certainly, a detailed building by building audit would have '*more fully'* identified deficiencies in the system. However, on balance, KRS/DHS already had a long and sufficient corporate knowledge of reports and failings. Each of those reports detailed areas that needed to be addressed. Many of those deficiencies and recommendations had not been systematically addressed long before the time ULA delivered its audit. The failure to address systematically the earlier recommendations meant that problem areas remained hidden. Even after ULA's audit, those problems remained, and many issues that were pointed out by ULA were not resolved at the date of the fire.

In the process of delivering any criticism to ULA, it must be remembered that its audit once again drew attention to the inadequacies of the fire safety system at KRS, and was the necessary key to provide for a total upgrade of the system. The MFB appropriately credits ULA/SSL with providing the necessary technical input to persuade CMB of the need to install sprinklers at KRS. The Warrington Report, commissioned by DHS after the fire, was supportive of the engineering principles of the ULA audit. It considered that the method of assessment '*was consistent with performance based BCA which was launched in October 1996'*.

THE ARRANGEMENT BETWEEN ULA AND SSL

It has been argued that ULA and SSL were joint consultants. Certainly, representatives of SSL were at the original interview when ULA was vying for the consultancy. They were involved at ULA's suggestion in direct discussions with KRS management on interim hardware solutions. This discussion occurred before delivery of the ULA Report in August 1994. The final report was delivered under the names of the respective organisations. The 'audit' of each residential building at KRS was conducted by SSL prior to delivery of the August 1994 report. The correspondence between ULA and SSL demonstrates a subcontracting role. ULA received a quotation from SSL for the audit work. Payment for the work was between ULA and SSL.[122]

The real nature of the arrangement between ULA and SSL is indicative of a subcontracting role. Although SSL's name was on the final report, it is not considered that this is sufficient to change the nature of that relationship.

(7) THE FABRIC SURVEY & BUILDING UTILISATION STUDY

As previously mentioned, in addition to the ULA Report, there is another document to be considered – the '*Fabric Survey & Building Utilisation Study: Part A Kew Cottages*'. The document was

119 Transcript, p. 3579.

120 Transcript, p. 3562.

121 See Exhibit 232, p. 7; Transcript, p. 5828.

122 Exhibit 169, pp. 34, 40. See, for example, correspondence between ULA and SSL providing and accepting quotations for the audit work at KRS at $11 610 (letters dated 7 June 1994).

completed in September 1994 by Group 4 Design Pty Ltd. It was prepared for 'Health and Community Services, Victoria – Capital Management Branch (CMB) and Disability Services Branch (DSB). The 'Client Project Team' included representatives from DSB, 'The Management & Staff Kew Cottages' and CMB. This is yet another document presenting warnings and solutions on fire safety to the State of Victoria.

It is noted that, after the close of evidence, it was discovered that the court exhibit copy of the Fabric Survey was missing its first pages. These pages (six in total) were obtained from the Solicitors representing the State of Victoria. The first six pages supplied provided additional information on the composition of the 'Client Project Team', contents, introduction, reasons for the survey, references and methodology. Where the information is important it is quoted in this section. It should also be noted that additional material, such as minutes of Project Team meetings, have not been sought at this late stage.

The introduction states that '*the study involved the conduct of a fabric survey, functional assessment and building utilisation analysis of rural and metropolitan training centres'*.[123] The opening remarks include the following:

> *The training centres have to some degree, obsolete buildings and architectural arrangements, which reinforce the difficulties of providing acceptable standards of accommodation and care. It is therefore necessary ... to develop a strategy for the upgrade of the standard of accommodation.*

The Survey was to include '*[t]he physical assessment of all on site buildings and engineering services'*. Reference documentation included *'Consultant Brief for Fabric Survey and Building Utilisation Study 1993, Disability Services 'Accommodation Design Guidelines and Existing site and building plans"*.

The Survey is critical in a number of areas ranging from the general maintenance of the buildings to the electrical system. On the issue of fire, the Survey comments that:

> *[r]ecent refurbishment works, whilst well intentioned, are in many instances 'ad-hoc' in nature or poorly executed in terms of the finished product. Additionally components of works that should have been included in the overall refurbishment eg. upgrading of services – particularly fire detection, have been omitted.*
>
> *In saying this however, it should be noted that such works have been carried out without access to significant funds. As a consequence the finished product has generally been compromised.*[124]

Under the heading '1.1.4 Conformity to Code Australia Standards/Disability Services Accommodation Design Guidelines', the Survey remarks that:

> *[g]enerally few buildings on the site meet the requirements of the Building Code of Australia/Australian Standards – particularly in terms of egress, fire detection, evacuation, ventilation and, in terms of office areas, – lighting levels.*[125]

Commenting on the 'Exit/Emergency Lighting', it is said that *'[m]any buildings have emergency/ exit lighting at the site although very few would comply fully to the BCA. In many cases exit lights, and emergency lights have been installed in 'ad hoc' fashion not considering the practical designated escape routes'*.[126] On the 'Emergency Evacuation System', it is commented that *'[n]o emergency*

123 Colanda, Sandhurst, Pleasant Creek and Kew Cottages.

124 Exhibit 128 – Fabric Survey, p. 3 (emphasis added).

125 Exhibit 128 – Fabric Survey, p. 3 (emphasis added).

126 Exhibit 128 – Fabric Survey, p. 9.

evacuation system exists at the site, however its effectiveness would be doubtful considering the nature of the clients'.[127] On the 'Fire Alarm System', the Fabric Survey is also critical. It states:

> *[m]any buildings at the site have some form of fire protection. This ranges from a single BGA (Break Glass Alarm) to full smoke and thermal detectors. Some upgraded buildings also have electromagnetic door holders for smoke control and electric strikes to release locked doors in the event of a fire alarm condition.*
>
> *During inspection it was noticed that many areas are not protected or have the wrong detectors installed eg. smoke detectors in laundries, thermal detectors in bedrooms, etc.*
>
> *The level of fire protection using smoke detectors is significantly higher than using thermal detectors, however, a trade off exists where detectors are used in inappropriate areas for false alarms and possible MFB charges. The fire protection system should protect the occupants before protecting the building.*
>
> *Many buildings did not comply with the Australian Standards and the BCA in terms of fire protection. A Maintenance Contract exists for the fire alarm system.*[128]

The Fabric Survey recommends upgrading of the exit/emergency lighting to comply with Australian Standards (with a maintenance program to AS 2293 Part 2); installing of '*effective and appropriate warning systems for the clients such as audible and visual alarms triggered by the fire alarm system.*'; and fully protecting the buildings using *'smoke detectors throughout except where false alarms would result (Bathrooms, Stores Offices, etc)'*.[129]

The 'Recommendations, (2.1 Generally/Residential Units)' suggest the development of a master plan where the following items should be considered:

- *Put into place a long term program (taking into account the masterplan for site) for the upgrade of fire detection and evacuation facilities for residential units, including egress provisions, to accord with the Building Code of Australia and any other relevant Australian Standards. ...*
- *Establish a mechanism to ensure appropriate professional design input into all future renovation works to ensure maximisation of design for monies available and conformity of works to relevant codes and standards.*[130]

The Survey also provides an audit (including fire systems) of Building 37.

On the use of the buildings at KRS, the Fabric Survey comments that planning of the '*large scale "institutional" buildings ... reflects the "dormitory" model philosophy of the past'*. Evidently, recent upgrade works have sought to improve the quality of residential units by installation of partitioning to the bedroom dormitories or through '*[t]he breaking up of the buildings into smaller functional residential units (flat-like) of around 7 persons per unit'*. The survey goes on to state that '*[t]he latter is generally the hospital's preferred model to be adopted across all future upgrades wherever practical*'.[131] It is noted that Unit 31 is divided into flats during 1995.

2.2.4 CORONERS' INQUESTS

(1) INTRODUCTION

In addition to the MFB fire reports and recommendations, in the recent years several fire and death investigations have been completed by coroners. Recommendations have been made in a number

127 Exhibit 128 – Fabric Survey, p. 9.

128 Exhibit 128 – Fabric Survey, p. 9 (emphasis added).

129 Exhibit 128 – Fabric Survey, p. 14.

130 Exhibit 128 – Fabric Survey, p. 12 (emphasis added).

131 Exhibit 128 – Fabric Survey, pp. 1-2.

of areas and apply to various agencies housing intellectually disabled and elderly residents. One recommendation applies to assistance in the management of an autistic child with fire-lighting behaviour by Health & Community Services. Generally, the coronial findings refer to sprinkler systems, smoke detectors (including hard-wired), evacuation procedures, training and fire audits.[132]

It is essential to draw attention to responses to coronial recommendation by the State of Victoria. These responses are dealt with in the following subsection of the Findings. It must be borne in mind that coronial recommendations are only advisory and not binding on the recipient. In many cases, recommendations must be considered and balanced in terms of wider priorities. The Coronial Service also acknowledges that there may be many competing issues to be considered by recipients of coronial riders or recommendations. However, what can be said is that the inquest process and recommendations have a capacity to draw attention to systemic problems which are, in many cases, avoidable.

(2) THE 1968 WILLSMERE FIRE

On 1 July 1968, a fire occurred at Willsmere Mental Hospital, Kew, resulting in the deaths of six female residents. Nearly all of the deceased were certified mental patients. The circumstances of this fire and some of the issues raised bear similarities with the fire at KRS on 8 April 1996. On completion of the inquest into the Willsmere fire, the Coroner found that the deaths occurred from carbon monoxide poisoning *'inhaled when the bedding of a certified mental patient caught alight as she was smoking in bed or performing an act associated with smoking and ignited B dormitory building of Ward F.9 of the aforesaid Hospital and ... (found that) ... such death was accidental'*.[133]

The Coroner delivered no riders with his findings. However, during the inquest, a fire expert – Mr William Snelling – recommended that:

> *the State Government consider, when finance becomes available, replacing the remaining three wards and associated staff buildings with fire resistant buildings using such materials as defined in Chapter 14 of Uniform Building Regulations, Victoria., 1961;*
>
> *Until the remaining three wards are replaced by fire resistant structures they be not used again to accommodate patients or staff because of their. hazardous construction;*
>
> *Serious consideration be given to the protection of all parts of the hospital, where patients are likely to be housed, by automatic sprinklers.*

Mr Snelling noted that *'[a]utomatic sprinklers maintain a 24-hour vigil immediately they are activated by the heat of the fire this causes an alarm to be sounded at the Fire Brigade and commences to discharge water over the fire. Such systems retard the spread of flame, heat and smoke logging'*.[134]

Mr Snelling was a member of the Institute of Fire Engineers and Chief Fire Protection Officer, Postmaster General's Department. He suspected that the cause could be attributed to a person smoking in bed. Snelling also opined that some incendiary agent was *'in all probability concealed in the bedding of that particular bed, its mattress or in the adjacent cupboard to that bed. It may well be that some flammable agent such as Shellite, Butane or other lighter fuel containers within*

132 Other coronial fire findings/recommendations relating to five deaths in custody (the Jika Jika fire Coroner's case file nos. 4771-75/87) and a fire at a boarding house (Majestic Hotel Coroner's case file no. 3633/90) may be useful.

133 Coroner's Brief – Police Arson Squad – Willsmere Inquest File. Refer Coroner's case nos. 2136, 2137, 2138, 2139, 2140, 2141.

134 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 16.

a cigarette lighter or a fuel container was the contributing cause in association with smoking material'.[135] There was evidence that the patient who started the fire may have used a cigarette lighter.[136]

When questioned by counsel assisting, Snelling remarked that '*if anybody was smoking in bed, which is not permitted by the regulations, if they were doing it in a manner which they were trying to conceal, then it is quite easy to ignite – I do not know for instance that the sheets were flannelette, I thought they were cotton, and that makes it even worse once it caught hold'*. The questioning continued:

> *I take it from the general tenor of your report that you regard this type of structure as a fire risk?— Most decidedly.*
>
> *And a structure in which it is unwise to house people who are not in full possession of their mental faculties?— That is quite right.*

On the issue of a locked door, Snelling said in evidence:

> *Was the risk that was there in any event exaggerated by the fact that the door at the Western end was locked from outside?— This could have meant that somebody might have escaped through that door and perhaps not so many people would have lost their lives* [although Snelling appreciated the need for security].[137]

Later, in evidence, District Fire Officer William Anderson of the MFB stated on the locked door issue:

> *I would agree with Major Snelling this building was a fire hazard. In my view the locking of the door at one end of the building could have contributed to the risk that was involved inasmuch as it would have made the removal of patients more difficult only having one entrance, and they may have had to pass the fire to get patients out that particular entrance.*[138]

The Sister in Charge Yvonne Gurr also agreed that the western door was locked from the outside as it '*is normal for the doors at one end to be fastened to stop patients wandering out of the ward*'.[139]

Assistant Chief Fire Officer William Seabrook was of the view that the locked door would not have altered the outcome. He described the alert system as a '*Pearson type thermostat at either end on the ceiling'* which was too far away from the '*central ventilating area, where the heat would concentrate, to give an immediate call'*. On the building, Seabrook said that*'[t]he construction of such wards should be in incombustible material where possible, and where this is not used, materials which slow the spread of fire must be selected'*.[140] On sprinkler systems, he said:

> *[i]t is recommended also that wards in such an institution be protected by automatic fire sprinklers, which, when they operate on a fire, not only give an early warning to the*

135 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 13.

136 Coroner's Brief – Police Arson Squad – Willsmere Inquest File. See Arson Squad interview with Mrs Tracey, pp. 55-56.

137 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, pp. 16-17.

138 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 32.

139 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 36.

140 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 49.

Brigade and Institution personnel but also keep down the temperature of the atmosphere and extinguish or control the fire sufficiently well to enable evacuation to be effected before it is too late.[141]

There was some discussion about the smoking issue and the fact that staff collected boxes of matches and cigarettes from the patients at night (see the evidence of Ward Assistant Antonia Kosorodov). The Coroner asked a number of questions on this issue:

Do you know what time it is usually when you go around and see if they are smoking or anything like that?— No, I was around at 7 O'clock with Mrs. Tracey there and I did not see her smoking at all.

Did you say anything at that stage to Mrs. Tracey about any cigarettes or matches?—I do not know; I cannot remember whether I said something ... [NOTE: it was suggested by another staff member – Maria Sacasan – that something was said by Kosorodov to Tracey about having previously warned her not to smoke].[142]

The Coroner also asked:

Are cigarettes and tobacco issued to the patients or do they buy them?—They can buy cigarettes or matches in the kiosk at any time. If I pick up one box of matches she can maybe hide somewhere ten boxes of matches that they can get in the kiosk.[143]

Ms. Kosorodov stated that she had not seen Tracey smoking in bed prior to the fire. It was because of this that she had never removed cigarettes or matches from Tracey. Also nobody informed Kosorodov that Tracey had previously been observed smoking in bed. Gurr stated that '*it has never really come to my knowledge that patients smoke in bed ...* [and] *... that is a matter which would come to my knowledge'*.[144] No complaints were made to Gurr that Tracey had smoked in bed.

Deputy Matron Margaret Ginnivan gave evidence on the smoking issue. On Mrs Tracey's smoking, she said that '*I know that she smokes, and on one occasion, approximately three months ago, I asked her to stop smoking while she was sitting on her bed'*.[145] The Matron did not inform other staff of this incident. On the smoking policy, Ginnivan stated that:

[t]he staff do not permit patients to keep cigarettes in the dormitories at night, and cigarettes and matches are usually collected from the patients and retained in the office. The patients may retain cigarettes in dormitories during the day, but there is objection to patients smoking while they are sitting or lying in bed ... [and] *... [t]hey should not have cigarettes in the dormitory, but they do.*[146]

The Matron commented that '*[w]e have to more or less allow the patients privileges, not like the custodian days when we had to count them and watch the cigarettes. Today they are allowed more liberty and we must get away from this custodial idea'*.[147] Further questioning by counsel assisting led to this interesting exchange:

141 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 49.

142 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 24.

143 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 25.

144 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 36.

145 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 44.

146 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 44.

147 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 46.

Evidence has been given that patients are not allowed to have matches in the wards at night; does that also apply to cigarette lighters?—Yes. I would say so definitely. It is not so many months since we have confiscated Shell lighters.[148]

The Hospital's Psychiatric Superintendent, Dr Cyril Burt, indicated that there was no written policy on patients smoking in bed. It was a matter of practice. However, there were difficulties in enforcing it without resorting to old (and unsatisfactory) practices of strip searching.[149]

A resident in the ward raised the alarm to the two staff on duty. By the time they arrived in the ward, the flames were about two feet high on the bed. Unsuccessful attempts were made to put out the fire by the staff, and the fire soon got out of control.

There was also some discussion about staffing levels at the time of the fire (about 7.15 p.m.). The Coroner's questions continued on this issue:

Are you in charge of three buildings there while you are on duty?—Yes.

Do you have anybody to help you on this particular night?—Yes, I have somebody there.

Who was that, was it Mrs. Sacasan?—Yes. Was there anybody else there at all?—No.[150]

Evidently, the sister in charge – Ms. Gurr – was stationed some distance away in an office and Sacasan fell on the stairs on the way to alert the sister to the fire. The distance was about 300 yards. By the time Gurr arrived at the scene, the building was blazing almost completely. District Fire Officer Anderson also stated:

On the other hand, the inmates of the building were not normal people and staff that were available at the time were not sufficient to be able to remove the number of people that were in that building in the time required to get them out in safety. I think it would have contributed to the patients being trapped there just the same.[151]

Sister Gurr acknowledged that they were *'a bit short staffed'* and that Mrs Sacasan who assisted the Ward Assistant was also the cleaner. She was considered to be nursing staff and a temporary ward assistant.

All staff were required to attend fire drills every two months. The drills were supervised by the MFB. There was also considerable discussion about the application of the then Victorian 'Uniform Building Regulations'.

The MFB Report for the fire on 8 April 1996 fire commented in relation to the 1968 inquest:

It was following this fire that recommendations from the Metropolitan Fire Brigade and the investigating member of the Post Master General called for, among other things, alarms, sprinklers and staff training to occur.[152]

(3) RECENT INQUESTS

More recently, coronial recommendations have been made in several general areas and in relation to the disabled.

148 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 46.

149 Coroner's Brief – Police Arson Squad – Willsmere Inquest File – Discussion, p. 47.

150 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 26.

151 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 32.

152 MFB Report 1.

THE ELLENER LODGE FIRE

On 2 October 1989, a fire occurred at Ellener Lodge, a Special Accommodation House in the Melbourne Suburb of Murrumbeena.[153] The fire resulted in the death of an elderly resident whose pyjamas had caught alight when the air outlet of a fan heater was blocked by his clothing, resulting in the build-up of radiant heat. Evidently, he had fallen asleep while watching television at night.

The Coroner's recommendations were forwarded to the Minister for Health, Minister for Aged Care, Minister for Local Government, Victorian Council on the Ageing and various other agencies. The Coroner commented:

> *The elderly, whether mentally or physically disabled or otherwise are very vulnerable to fire especially at night and in low cost accommodation with poor fire protection.*
>
> *As a group, the elderly suffer a disproportionate share of deaths and injury during fire. So often death is caused by asphyxia and injury, by the inhalation of smoke and toxic fumes.*
>
> *Obviously, in the context of a SAH, boarding house, nursing home etc. it is crucial that a fire be detected early so that staff, residents and the fire brigade may be warned, the fire suppressed or contained and the premises evacuated.*
>
> *So often at the early stages of a fire the same is not observed and smoke is not smelt until it is too late.*

The Coroner also made the point that senior citizens:

> *forced to seek accommodation in an SAH should not be subject to a lottery of different standards of fire protection dependent upon the date of building permit or whether or not the premises were designed to accommodate more than 20 residents.*

The Coroner made a number of pertinent recommendations, which included installation of smoke detectors and residential sprinkler systems. He said that:

> *proprietors of all existing SAH's irrespective of when they were built or how many persons the SAH was designed to accommodate, be required to install, if not already installed, and maintain a suitable smoke detection and alarm system and also an emergency warning and communication system to the satisfaction of the Chief Fire Officer or his delegate.*

The Coroner recognised the need to use domestic-type smoke detectors wired to a central point as an alternative to the more expensive options required under the Building Regulations. The finding canvassed the application of the Building Regulations and the *Building Control Act*. The Coroner proposed a more flexible system for addressing deficiencies in fire standards by amending the Building Control Act and making use of the expertise of the Chief Fire Officer. It was suggested that the Chief Fire Officer have '*greater powers and a more decisive role in addressing deficiencies in fire standards which may be remedied with relatively little expense'*. The Coroner also encouraged the marketing of cheap residential sprinkler systems, and on the issue of staffing at night, stated:

> *[t]hat the Department of Health give consideration to requiring SAH proprietors to increase the level of staffing, particularly at night in those SAH's which do not have a suitable smoke detection and alarm system in place. Further, that in these circumstances that staff be required to 'do the rounds' more often during the night than the current regulations require (once before 10 pm).*

Other coroners' findings are dealt with under topic headings.

153 Coroner's case file no. 4240/89. Note: This inquest finding was not part of the material dealt with during the hearing. It was discovered after the close of evidence.

SPRINKLER SYSTEMS

On 13 July 1990, the Coroner investigating the 'Caloola Fire'[154] commented:

> *In view of the nature of the Institution and its clients it appears appropriate that such a regular report and assessment should be undertaken. Such a report will no doubt address the issue of evacuation of bedridden patients and further consider sprinkler systems in priority areas. This is not to suggest that sprinkler systems are required but certainly it is a matter for consideration.*

The Caloola Training Centre fire occurred at the Sunbury complex on 6 August 1988 and was started by a resident. The fire was started in an accommodation area that was in the process of renovation. There were no deaths. At that time Caloola housed approximately 510 intellectually disabled residents supported by 750 staff. At the time of the inquest, Caloola had been earmarked for closure in 1993. It has since closed. In the finding, the Coroner further commented that '*[i]t is understood that since the 1988 fire $1.5 million has been spent on fire precautions and a further $.5 million is to be spent over the next 3 years prior to closure'*.

On 27 July 1992, in making recommendations following an investigation into the Leige Court/ Athol Lodge fires, the Coroner stated that:

> *American Standard NFPA 13R Residential sprinkler systems [must] be made mandatory in all supported residential services.*
>
> *This would obviate any requirement for smoke detectors to be automatically linked to the local fire station, and would save that expense.*
>
> *While there is merit in the idea of assessing the need for sprinkler systems on a case-by-case basis, I am persuaded by the evidence I have heard that on balance the more appropriate recommendation is for sprinkler systems and smoke detector systems to be mandatory. The most persuasive factors supporting this are:-*
>
> *(i) The fact of ten deaths by fire in supported residential services within a 9 month period;*
>
> *(ii) The fact that residents in such services may have reduced mobility and independence in the circumstances of a fire by reason of their age, frailty or intellectual or physical disability, even though they might otherwise qualify as residents of a supported residential service.*
>
> *(iii) Currently accepted staff ratios, while satisfactory for most purposes, are not adequate for the evacuation of a large number of residents who would generally belong to the categories of age, frailty, or intellectual or physical disability. The ability of a sprinkler system to put out a fire (even though this cannot be guaranteed), cannot be bettered by any other available system on a premises and might obviate the need for evacuation, or at least reduce the urgency, and so save residents from both smoke and flame.*
>
> *16. I make these recommendations in the knowledge that their implementation will be costly and that the cost may mean that in some cases, a supported residential service may have to close. However, the best interests of the community would be served by the requirement of high fire safety standards to assist in the protection of those who are often unable to assist themselves and depend on others for their protection.*

In the Leige Court fire, four elderly residents died on 16 April 1991. Leige Court was a 'Class 3' Special Accommodation Home which specialised in the care and accommodation of elderly persons

154 Coroner's case file no. 3349/88.

suffering from senile dementia. The Leige Court fire inquest was conducted jointly with another fire inquest in a Special Accommodation Home – Athol Lodge.

Leige Court was equipped with fire extinguishers, two fire hose reels, and three break-glass alarms, which were not connected by telephone line to the local fire station. There were no smoke detectors or sprinklers fitted. The building met all existing fire safety requirements, and the provision of a staff member on duty was in excess of the requirements, which are that a person is to be on the premises, available in an emergency, but not requiring that person to be on duty. The Coroner found that the fire was caused by one of the deceased residents smoking in bed.

In the Athol Lodge fire, which occurred on 29 January 1992, six elderly residents died. Athol Lodge:

> *had seven stand-alone battery-operated smoke detectors fitted, although not all of these were correctly installed at ceiling height. One was fitted in a resident's bedroom to deter him from smoking and another was fitted outside the bedroom of (the resident who started the fire). One was located on the architrave of the door to the television room. However, none were connected to the Manager's quarters, and he could not hear them with his door shut. There were also fire extinguishers, a hose reel and a hydrant on the premises, and all the equipment met fire safety requirements.*

In addition, the Coroner commented in relation to smoke alarms and sprinkler systems:

> *If the smoke detectors had been correctly fitted and connected to the Manager's room, he would probably have had a considerably earlier warning of the fire and could possibly have prevented residents being affected by smoke inhalation. Smoke was later found to have pervaded all open areas of the building with closed rooms being relatively unaffected. It is also believed that had a sprinkler system been fitted, to operate when the temperature reached 68 degrees Celsius, the fire would have been extinguished before smoke could have escaped in sufficient volumes to cause harm.*

When generally commenting on the Leige Court and Athol Lodge fires, the Coroner said:

> *1. Concern has been growing from some time at the risk of fire in special accommodation homes, now called supported residential services (S.R.S.). These homes operate in the private sector for profit and do not receive government subsidies. They offer supportive residential care for the frail aged and for people with intellectual disability or psychiatric illness, and they number 350 in Victoria. They are regulated by the Health Services Act 1988, and are visited by members of the Health Department, and by community visitors of the Office of the Public Advocate. In the Annual Report of the Community Visitors for 1991, the issue of smoking and fire safety in supported residential services, was raised. Visitors were alarmed at the lack of fire safety in the places they visited, and believed there were problems of policy and regulatory fragmentation. This Report was made several months after the fire at Leige Court, and before the fire at Athol Lodge. The Report recommended that the Health Department consult with fire authorities about necessary measures to be put in place to ensure fire safety. This is now being addressed by the Health Department, as I have already described. The Report also referred to the Building Code of Australia which took effect in April 1991, requiring Class Three buildings, which includes supported residential services, which sleep more than 20 people to have an automatic fire alarm system connected to the nearest fire station. The concern expressed was that this requirement will only be made of newly built supported residential services.*
>
> *2. The Victorian Health Services Commissioner visits homes in response to complaints, and matters of fire safety may come to the Commissioner's attention in this way. The Commissioner expressed concerns to the inquest that, in particular, long-standing fire*

orders (Joint Reports) have not been acted upon, in some cases, and that the recent action taken by the Health Department initiating fire safety recommendations in S.R.S.'s may lack sanctions. The Commissioner's experience has been that fire safety improvements are often delayed by proprietors because of real or feigned confusion over what is expect of them. This appears to tally with the experience of the community visitors.

The Coroner also made additional comments relating to the mentally disabled and fire safety problems, delays in fire safety works, the need for a higher standard of fire safety at night, and the Building Control Act.[155]

An inquest into two deaths during a residential fire on 18 September 1992 examined the fire-lighting behaviour of an autistic child being managed by the Department of Community Services (THI Huot Ly and TRAN Moc-Qui inquests).[156] Under the heading 'Residential Sprinkler Systems', the following comment was made:

During the inquest evidence was given about the effectiveness of residential fire sprinkler systems. In this case, had a sprinkler been installed, the rapidity of the fire spread may have been reduced (or eliminated) and the resultant property damage, injury and death outcomes would probably have been avoided. In view of the cost of the installation of such a system (in the vicinity of $2000 for an average suburban house) where there is a significant risk of repeated fire lighting behaviour installation of a sprinkler system may be an appropriate hazard management technique.

Recommendation 4
Where there is high risk of fire associated with repeated fire lighting behaviour – installation of residential fire sprinkler systems may be appropriate to reduce the damage to property and potential for injury.

On 20 October 1995, in the Melton Court Hostel fire inquest,[157] the Coroner made recommendations on sprinkler systems. Melton Court Hostel provided accommodation for the

155 See the Coroner's further comments:

... 3. The problem of Joint Reports not being acted upon gave rise to the suggestion that the power could reside in The Department of Health to not permit registration of the premises if minimum fire safety requirements are not met.

This possibility is favoured by the Public Advocate for Victoria, Mr Ben Bodna, and by the office of the Health Commissioner. The Public Advocate's statutory role is to safeguard the dignity and well-being of the mentally disabled, and to report to the Minister of Health. The Public Advocate reports regularly to the Department of Health as to problems noted by community visitors, and these include fire safety problems. The Health Commissioner's statutory role is to investigate complaints made of service providers, and complaints received may include complains about fire safety. Both these statutory bodies have experienced delay in the implementation of fire safety works, the need for which has been reported by them to the Health Department. For these reasons they consider the Health Department's power of registration could be used effectively to bring fire safety up to standard.

4. However, the Department of Health does not agree, believing that such enforcement should remain in the hands of those with fire safety knowledge, that is, municipal building surveyors, and the Chief Fire Officer. It would seem desirable that this should remain the case, and that efforts should be made to encourage voluntary compliance with adequate standards before a Joint Fire Report is issued. It becomes necessary for the Minister to consider closure of the building, such a decision would be made in the knowledge that negotiations had occurred at an early stage.

5. An amendment to the legislation to enable this, would in effect commit to legislation the strategy presently being used by the Department of Health, and initiated by the St Kilda Council.

6. The legislation would need to be amended to allow entry of premises by Councils, as this is currently prevented by Sections 1645 and 165 of the Building Control Act, unless for the purposes of conducting a Joint Fire Report. I have made this recommendation already in my finding relating to the fire at 33 Grey Street, St Kilda.

7. In March 1992, the Residential Services Fire Safety Committee reported its recommendations to the Minister for Health. The Committee was established by the Health Department following the fire at Athol Lodge, to investigate and make recommendations on fire safety in existing supported residential services.

The Committee, comprised of a number of interested parties including the Fire Services and the Association of Supported Care Homes, did not achieve consensus about a single solution to the problem, but found much common ground and reached consensus about a three phased strategy, which has now been put into place. The Fire Services supported the mandatory installation of residential sprinklers (the cheaper system using plastic piping rather than the more expensive system complying with Australian Standard 2118 which used copper piping). Their support of sprinkler systems is based on their ability to suppress fires and minimise dependence on management responses, evacuation and emergency procedures, and therefore to reduce the risk of death or injury.

8. Other parties argued that a combination of other approaches, for example, systems incorporating smoke and thermal detectors hard-wired to the fire services, could be sufficient to improve fire protection for residents.

It was emphasised that the fire risk for existing buildings depends substantially on the individual fire safety features of the building, and this needs to be assessed on a case by cases basis. These positions were all explained in detail at the inquest.

9. The three phased strategy was to require the achievement of a number of goals in each of three periods. Without repeating the details here, it is sufficient to describe the following:

Phase One, to be achieved within one month, is to require proprietors of supported residential services to install stand-alone battery-operated smoke detectors in every corridor, and to ensure compliance with existing fire protection regulations.

Phase Two, to take six months, is to emphasise prevention strategies, and an accelerated program of building inspections. In practice, this means training of staff in fire safety, and the assessment of each supported residential service in Victoria. This would result in the discussion of works programs between the inspection teams, the proprietor and the property owner, and would take place pursuant to Part VIII of the Building Control Act 1981.

Phase Three, is to be completed within three years, and consolidates the work already commenced and intended to continue.

10. The recommendations give recognition to the need to assess existing buildings, and to require such fire safety improvements as might be necessary case by case. The evidence heard in the inquest suggests that all parties are aware of the issue of cost, and the role this might play if expensive alarm and/or suppression systems were made mandatory in supportive residential services. In some cases expensive systems are affordable, and would not force the proprietor to close if made mandatory. In other cases this might not be so. It is recognised that if high standards of fire safety are to be mandatory, part of the cost of the community and to individuals will be the loss of some services. However, it is observed that whilst some may close, others will open up, and be in a position to absorb the extra cost.

11. The recommendations of the Committee may be amplified by reference to two of the submissions the Committee received, one from the City of St Kilda and one from Aged Care Victoria Inc. The evidence of Mr Bowden, of the Association of Supported Care Homes is also taken into account.

12. The City of St Kilda submission anticipated the Committee's recommendation that smoke detectors should be installed, and proposed that fire safety requirements should be stricter than this. The submission written in large part in 1990, covered rooming house, special accommodation homes and hostels, nursing homes, and back-packer hostels, and thus its ambit was wider than the Health Department's Committee. I shall limit my attention to special accommodation homes, because of the direction taken by the inquest, but bearing in mind that the broader recommendations I intend making would apply to other buildings as well, by the application of Section 1333 of the Building Control Act.

13. The City of St Kilda recommended that Special Accommodation homes should be required to have electrically wired smoke detectors, should be encouraged to have residential sprinklers if the premises is of one storey, and required to have residential sprinklers if the premises is two storeyed. The issue of tenant mobility played a part in this recommendation. The evidence heard suggests that although residents of special accommodation homes are supposed to be generally mobile, there are cases of restricted mobility, and these might include as examples, those whose frailty or lack of balance necessitates a walking frame, and those who are blind or who have impaired vision. Fire safety requirements would take such matters into account, and it would follow that if a particular residential service took high numbers of confused or demented residents, such disability would equate with immobility in the confusion of a fire, particularly at night, and would be the basis for a higher standard of fire safety being needed.

156 Coroner's case file no. 3055/92.

157 Coroner's case file no. 864/94.

aged. In the fire, which occurred on 13 April 1994, five elderly residents died. The fire appeared to have started on a couch in the common room of the hostel. The Coroner's recommendations on sprinklers were:

> *a) The proprietors of Melton Court faced a dilemma over residents smoking, that must be common to many proprietors of special accommodation houses or supported residential services. There was an appreciation of the potential fire risk in the absence of a stringent smoking policy and knowledge of some residents who were so set in their ways, that they would not comply with the introduction of a safety policy. There is agreement by all experts, that the most effective fire suppression method, is the use of automatic fire activated sprinklers which are designed to suppress the fire before it can develop or spread. The benefit of such a system in accommodation houses is obvious, given that the residents are invariably elderly and impaired, either physically by frailty, loss of hearing and sight, or mentally by becoming easily confused.*
>
> *Against mandatory installation of automatic sprinklers in existing supported residential services is the substantial cost, generally to be borne by the proprietors who often face financial difficulties. There is little doubt that the mandatory requirement would have a potentially significant social impact as some businesses may become non-viable and be forced to close, resulting in a lack of care and accommodation. Nevertheless it is appropriate to recommend that automatic sprinkler systems be made mandatory in all supported residential services. In order to meet the installation costs, consideration could be given to requiring contribution from both owner and proprietor, as well as providing Government financial incentives.*

STAFFING LEVELS IN FIRE EMERGENCY

The Coroner in the Melton Court Hostel fire inquest made the following additional recommendation on staffing levels:

> *b) It is further recommended that consideration be given to reviewing staff/resident ratios for night management in supported residential services.*

FIRE AUDITS

In the Caloola fire inquest, the Coroner suggested that:

> *[a] regular (Annual) Fire Report ... be undertaken as soon as possible by the Country Fire Authority.*

SMOKE DETECTORS

In the Leige Court/Athol Lodge fires inquest, the Coroner remarked in the course of general comments that '*[t]he City of St Kilda recommended that Special Accommodation homes should be required to have electrically wired smoke detectors'*. In addition to earlier comments in the Athol Lodge fire inquest, she said in support:

> *The issue of tenant mobility played a part in this recommendation. The evidence heard suggests that although residents of special accommodation homes are supposed to be generally mobile, there are cases of restricted mobility, and these might include as examples, those whose frailty or lack of balance necessitates a walking frame, and those who are blind or who have impaired vision. Fire safety requirements would take such matters into account, and it would follow that if a particular residential service took high numbers of confused or demented residents, such disability would equate with immobility in the confusion of a fire, particularly at night, and would be the basis for a higher standard of fire safety being needed.*

MANAGEMENT OF FIRE-LIGHTING RISK OR BEHAVIOUR

In the Leige Court fire inquest, the Coroner found that:

> *there was a policy of "no smoking" in the premises, except for the television lounge, where smoking was tolerated but discouraged. It was preferred that residents smoke outside, and smoking was strictly forbidden in the bedrooms. The supply of cigarettes was controlled and limited in respect to each resident.*

It was stated that two of the residents were smokers, with one of the deceased, who was found to have caused the fire '*having a very strong urge to smoke. He had been found on occasions to have cigarettes and cigarette butts secreted in his room and in his clothes. Cigarette butts had been found on the ground outside his bedroom window. He had been warned frequently not to smoke in his room'.*

In the Athol Lodge fire inquest, the Coroner commented:

> *Evidence was heard that there was a strict policy of no smoking in the bedrooms of the home, and that smoking was permitted only in the television lounge, on the ground floor near the front door. Tin cans were provided as ash-trays in that room and were emptied each evening by the manager's assistant before she retired to bed. The manager habitually locked the dining room and the kitchen doors, and checked the television loungeroom.*

The fire was started by a resident who *'came to the manager and asked him for a cigarette. He gave her two and lit one for her, which she smoked straight away. The manager did his nightly rounds between 9.00 and 9.30 pm and found all the residents ... in their beds. At 10.20 pm (the resident who started the fire) awoke the manager telling him there was a fire'.*

As mentioned, the THI Huot Ly and TRAN Moc-Qui inquests raised the issue of the fire-lighting behaviour of an 11-year-old autistic child. TRAN Moc-Qui was eligible for Intellectual Disability Services, and his parents regularly sought assistance from Health & Community Services in managing his behaviour. The child set fire to his home in which both he and his mother, Mrs. THI Huot Ly, died. On 2 March 1995, in the finding, the Coroner summarised part of the problem as:

> *The Health & Community Services Response*
>
> *It is difficult to understand how, between 1990 and 1992, an experienced government agency like H&CS could so clearly miss the point about fire and resultant risk to individual safety. 'Risk assessments' appear to have been a regular part of the responsibilities of H&CS workers. In spite of regular and detailed psychological assessments and reports, which frequently mentioned risk – fire and the obvious link to injury was not made. There has been some suggestion that the family did not specify a need to have assistance relating to the fire issue and that home inspection indicated the family were managing this behaviour. This suggestion misses the point. There was a misconception by department officers about the effectiveness of the family's fire management strategies which indicates the officers were working outside their field of expertise in assessing fire risk.*
>
> *Whilst the family did not apparently make the necessary early connection between fire and individual safety or serious property risk, the failure by H&CS to seek preventative advice from a specialist agency such as the Metropolitan Fire Brigade following clear notification of circumstances where individuals were at risk is difficult to rationalise.*
>
> *There has been comment that the understanding of fire safety issues by officers within H&CS has developed along with general community knowledge. However, the agency having accepted as part of its professional responsibility a 'risk' assessment, also has responsibilities to properly assess and advise. At the very least, having identified a potential hazard, it needs to direct its clients to agencies with required specialist knowledge.*

In summary the failure by H&CS to adequately address the fire lighting issue may have related to the following factors:

(a) The general lack of community awareness of fire prevention issues

(b) The concentration of H&CS psychologists and staff on behavioural related issues (as distinct from environmental)

(c) The lack of appropriate 'risk' assessment training for H&CS officers

(d) Concentration by H&CS officers on the 'main' behavioural issue that of 'tantrums', and,

(e) The mistaken belief the family were managing the fire lighting behaviour.

However, following this fire, H&CS have developed strategies to avoid repetition of this type of incident. Those strategies also involve a recent general departmental direction as to risk and a specific direction dealing with fire. The comments about fire are:

'Staff must take particular care where a client or family/carer is involved with dangerous behaviour with fire. Staff must discuss with the client/family/carers all reasonable precautions, including the use of smoke detectors, whether or not the client is living in their own accommodation.

Where a young person is involved in risky behaviour with fire, staff should also consider a referral to the Metropolitan Fire Brigades' Juvenile Fire Awareness and Intervention Program or similar program offered by the Royal Children's' Hospital.' (Dr John Patterson, January 1995)

It is important that systems failures be identified at an early stage and protocols developed. Recently H&CS have also been involved, as the lead agency, in developing an injury prevention strategy for Victoria (called 'Taking Injury Prevention Forward – Strategic Directions for Victoria 1994') which includes 'fire' prevention as one of the specific areas. The department is now working with the State's fire agencies and no doubt this integrated approach will assist in reducing the potential for incidents such as have been examined in this inquest.

Recommendation 1
That the Fire Authorities and Health & Community Services consider a joint team approach to managing children with intellectual disability and fire lighting propensity (or fire lighting propensity alone). As family involvement and commitment is essential to maximise the potential for success of any fire intervention program a team approach may be of benefit.

As the officers from H&SC concentrated on issues associated with behavioural management and the relationship of behaviour to risk they failed to fully consider the relationship between behavioural and environmental factors. The professional methods of assessment of risk by the department where behavioural problems are being considered need review to include other factors.

Recommendation 2
That the Department of Health & Community Services consider developing a specialist training program to assist staff in identifying recent developments in modern hazard management strategies (see for example the program being currently developed by the Victorian Occupational Health & Safety Authority). Such a program would need to be suitable for the type of work undertaken by the Department.

EVACUATION PROCEDURES AND TRAINING FOR FIRE MANAGEMENT

In the Caloola fire inquest, the Coroner recommended:

> *[t]he further development of a Fire Training and Evacuation Procedure with the assistance of an outside organisation such as the Country Fire Authority.*
>
> *Such a system should include further attention to hands-on training for a broader range of staff.*
>
> *It is understood that the System of training already developed internally has become recognised as the system for other State Enrolled Nurses. It may be useful for the System of training to be further developed with the input of outside fire fighting professionals and be used by similar Institutions throughout the State. Consideration should also be given for the use of the portable beacons in other similar institutions.*

(4) RESPONSES TO INQUEST RECOMMENDATIONS

The Reply by the State of Victoria set out in some detail its response to a number of the listed inquests/coroners' recommendations. The State's Reply referred to a comment by the Public Advocate to the effect that by virtue of a number of inquests DHS could be imputed to have:

> *long standing knowledge about the safety shortcomings of KRS which demonstrate the culpability of the Department and the justification for a finding that it had contributed to the tragedy through its indifference and effectiveness in its inaction to the known risks.*[158]

The Reply also notes the MFB submission '*that these coronial findings, though not conducted in relation to fires and deaths at KRS, ... are relevant to the issues of fire safety at KRS and which, according to the MFB, were sufficient to "place the government on notice as to the risk of hazardous fire occurring.*" *Indeed the MFB submit that it is evident from the evidence tendered at the Inquest that "government knew earlier than but at least from 1989" that there was a serious risk to the lives of residents at KRS'.*[159]

An examination of the responses to various inquests shows that the use of the term *'indifference'* by the Public Advocate is not justified. The response indicates a considerable amount of work on the issue of coroners' recommendations.

ON THE RESPONSE TO THE LEIGE COURT AND ATHOL LODGE INQUESTS

The State of Victoria's Submission in Reply pointed out that Athol Lodge and Leige Court were both Supported Residential Services (SRS) registered under the *Health Services Act* 1988. In 1992, after the fires at these two services, the Minister for Health under the previous government established an advisory committee to investigate and make recommendations on fire safety in SRSs. The committee was made up of representatives from government departments and industry representatives. The State of Victoria submitted that:

> *[i]n response to the report and recommendations of the committee the government moved swiftly to establish a process whereby the fire protection for residents in all the SRSs then in Victoria could be improved. A key recommendation of the report was the establishment of a special Fire Risk Assessment Unit (FRAU). The Unit received specific funding from the Department of Finance for a six month period. It included officers from the Former Division of Building Control with the DPH, and officers of the MFB and CFA.*

158 State of Victoria Submission in Reply, p. 238, para. 6.13; Public Advocate's Submission, p. 52.

159 State of Victoria Submission in Reply, p. 243, para. 6.25; MFB Submission, p. 146.

An implementation Steering Committee was established to oversee the programme. The task of the FRAU was to inspect all SRSs in the state and prepare reports on each.[160]

The Fire Risk Assessment Unit was disbanded in late 1992. Apparently, in lieu of FRAU, it was suggested:

In a letter to all councils of 8th September 1993 the Minister for Planning, the Hon. Robert McLellan, requested that councils implement a joint report under Part 8 of the Building Control Act to ensure that acceptable safety levels in SRSs were met.[161]

ON THE RESPONSE TO THE MELTON COURT INQUEST

In 1995 the Deputy State Coroner reported on a fire at a hostel in Melton which killed six residents. The State in its Reply notes that the Coroner recommended sprinklers, and comments that:

[i]t is important to note that Melton Court was not a SRS registered under the Health Services Act, but a hostel funded and monitored under Commonwealth legislation. SRSs are responsible to the Department of Human Services for their day to day operations, nursing homes and hostels to the Commonwealth Department of Health and Family Services and rooming houses to local councils.[162]

The Reply observes that during '*the inquest into the deaths at Melton Court officers of the then Department of Health and Community Services gave evidence that Melton Court was a hostel and that relevant legislation regulating hostels was administered by the Commonwealth. An officer of the Victorian Building Control Commission also gave evidence that the regulation of fire safety and protection was the responsibility of the Building Control Commission'*.[163] Apparently, critically, the State says that:

[d]espite the fact that Melton Court was a hostel and not an SRS, the Coroner in the Melton Court Inquest found that automatic sprinkler systems should be mandatory in all SRSs. The Coroner recognised in her findings that the installation of sprinklers in such accommodation required substantial cost. In a letter to the Coroner the Department of Health and Community Services noted that the finding in the inquest related to SRSs while Melton Court was actually a hostel.[164]

But the coronial finding into the fire at Melton resulted in the Minister for Aged Care referring:

the coronial report to the Minister for Planning to pursue the matter under the Building Control Act. The Minister for Planning advised the Australian Building Codes Board of

160 State of Victoria Submission in Reply, p. 239, para. 6.14. The State further submitted that:

293 of the approximately 310 SRSs then registered were inspected by the FRAU. The 17 not inspected were either closed for renovations or were subject to a statutory joint report process under Part 8 of the Building Control Act 1981. These provisions allowed for local councils to require fire safety measures to premises.

The majority of SRSs which were inspected were considered satisfactory in that they met or substantially met the minimum requirement of hard wired smoke detection and fire rating. Five SRSs were considered to be in urgent need of work to achieve the minimum standard. FRAU sent a copy of the report to each owner/proprietor with a request that they give a commitment to implement the recommendations over a three year period.

The implementation of the recommendations of the FRAU reports was encouraged and strongly recommended. The sanction available in the event of non-compliance was closure under the Building Control Act if a building was considered to be dangerous. (See pps.239-40 paras.6.15-6.17).

161 State of Victoria Submission in Reply, p. 240, para. 6.18.

162 State of Victoria Submission in Reply, p. 241, para. 6.19.

163 State of Victoria Submission in Reply, p. 241, para. 6.20.

164 State of Victoria Submission in Reply, p. 241, para. 6.21.

the Coroner's recommendations as that Board was then considering amendments to the Building Code of Australia for new residential aged care buildings.[165]

It appears that the three recent fires in residential care accommodation have resulted in some changes. The State's Reply comments further that:

[i]n respect of existing buildings the Building Control Commission has recently released a Regulatory Impact Statement (Exhibit 298) which recommends the introduction of a five year period for upgrade of existing buildings, including the provision for sprinkler systems or their equivalent. Draft Regulations prescribing these provisions were circulated and the Regulatory Impact Statement included a detailed financial analysis of the impact of the proposed regulations on a wide range of supported accommodation. As it is noted in the Regulatory Impact Statement, a prime motivation for the proposed changes has been the fires in the above three accommodation services as well as the fire at KRS, the subject of this Inquest.[166]

ON THE RESPONSE TO THE INQUEST OF MOC-QUI TRAN

Following the Tran finding, strategies were developed to avoid a repetition of the type of incident that occurred. In summary, the strategies involved:

a general departmental direction as to risk and a specific direction dealing with fire. See the Departmental memorandum from the Secretary of the Department to staff dated January 1995.[167]

A memorandum was:

circulated as part of the Mental Health Services Programme management circular in July 1995 entitled "Fire Risk Behaviour – Reasonable Decision Making". The Disabilities Services Branch of DHS and the Disabilities Services Training Unit assisted the MFB in the development of a training programme and video for staff about fire safety in community residential units.[168]

More detailed strategies have now been developed, and the inquest:

has been presented with the results of the review of all regions of the Department showing where clients have been identified as having fire lighting behaviour, the extent to which client services staff have been alerted to the need to ensure safety measures are in place for clients who exhibit such behaviour and such other action as has been taken in each region to address the issue raised by the Tran inquest.[169]

2.2.5 COMMUNITY VISITORS' REPORTS AND THE PARENTS' ASSOCIATION

The State of Victoria in its Reply accepts that various Community Visitors' Reports published under the auspices of the Public Advocate's Office pursuant to the *Health Services Act* 1988 *'identify deficiencies in the fire protection system in residential care institutions and recommend the upgrade of those systems'*. It acknowledges that the Parents' Association *'pursued the question of early warning alarms and sprinklers over an extended period'*.[170]

165 State of Victoria Submission in Reply, pp. 241-242, para. 6.22.

166 State of Victoria Submission in Reply, p. 242, para. 6.23.

167 State of Victoria Submission in Reply, pp. 242-243, para. 6.24.

168 State of Victoria Submission in Reply, pp. 242-243, para. 6.24.

169 State of Victoria Submission in Reply, pp. 242-243, para. 6.24. See Exhibit 258.64 – Pam White's statement, para. 6.

170 State of Victoria Submission in Reply, p. 244, para. 6.27. See also Community Visitors' Reports for years 1991-1993.

2.2.6 GOVERNMENT DIRECTIVES AND ADVICE

(1) BUILDING APPROVALS AND GOVERNMENT DIRECTIVES

Significant work has been undertaken in recent times to bring building standards in the public sector to an acceptable fire safety level. In 1993, amendments were made to the *Building Act* 1993, and Guidelines were published by the Minister for Finance in November 1994. The Guidelines were entitled 'Standards for Publicly-Owned Buildings', and developed by the Office of Building of the Department of Planning and Development. They were intended to promote better building standards for buildings owned by the Crown and public authorities. This move was considered to be a major development in the important area of building control.[171]

(2) SMOKE DETECTORS

In June 1992 Ms. Laurie Bebbington, Director of Industrial Relations and Workcare for the Department of Community Services Victoria, sent a memorandum dealing with the installation of smoke detectors, which states:

> *Statistics prove that the majority of fatalities in fires between 2am and 5am are caused by smoke asphyxiation. Early smoke detection is essential to avoid serious injury and death.*[172]

Along with this memorandum came another memorandum from Mr Brad Edgar, a Works and Assets Manager with Community Services. It related to community-based residential facilities and did not apply to institutions such as KRS. [173] Mr Taylor, Facilities and Services Manager, KRS, did not remember the memorandum from Edgar. However, he did recall *'a document with the intent of this around this time'*.[174] His immediate response was to engage FFE to install smoke detectors at KRS.

An information circular was distributed within Health and Community Services in April 1994 by Mr Alan Clayton, Director of Resources in the Department. The circular stated:

> *Recent joint research by CSIRO and the Department has determined that the response time of smoke detectors is far superior to thermal detectors and will provide significantly quicker detection of smoke or an incipient fire. There is widespread recognition that smoke alarms can save lives. They give the earliest warning of a fire and allow precious time to either extinguish the fire or evacuate the occupants.*
>
> *RECOMMENDATIONS*
> *All thermal detectors located in bedroom, corridors, lounges, wards, treatment areas, and dining areas to be progressively replaced by hardwired smoke detectors.*
>
> *For smoke alarms to be effective it is important that they are adequately maintained. A maintenance schedule for checking smoke detectors should be instigated in accordance with manufacturers instructions.*[175]

There was no evidence that this circular or the information contained therein was distributed to the maintenance contractor – Jonkar Industries.

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171 This issue is discussed in detail in the Findings in **PART 5. Building Law and the Fire 5.1.1 Background; 5.1.2 Legal and Historical Overview.**

172 Exhibit 240, dated 18/6/92.

173 Exhibit 239.

174 Transcript, p. 5397.

175 Exhibit 238.

2.2.7 CONCLUSION: A COMPARISON BETWEEN RISK AND LIKELIHOOD

The Reply of the State of Victoria makes the point that it '*must be accepted as a result of the various reports and advices ... that fire safety risks, that is, potential for harm to persons or property in the event of fire, was evident within the KRS complex (not necessarily Flat E of Unit 31) because of the inadequate fire protection system'*.[176] But it seeks to say that the argument by the MFB and the Public Advocate *'that the inaction by DHS was fundamental in assessing DHS's culpability'* ignores the fact that the Department is a '*relatively recent arrival*' in administering KRS. It is pointed out that:

> *successive governments, a range of government departments, local councils, the MFB and an informed section of the community, were aware of the level of inadequacy of the fire protection system and the lack of priority being given to its rectification. Some parties, and in particular the MFB, have persistently referred to DHS as though it were at all times the relevant government department and the sole repository of what in fact was a collective communal wisdom about the state of the fire protection system at KRS.*[177]

However, it is noted that Mr Taylor, Facilities and Services Manager, KRS, was given responsibility to implement major fire upgrade works recommended by the MFB in 1988. He wrote, with some frustration, to the Ministry of Housing and Construction on 7 August 1989, saying:

> *You should be aware that over 750 intellectually disabled people are accommodated at this Centre. Many of these people have profound physical and intellectual disabilities and would be placed at enormous risk in the event of a fire.*
>
> *The management of Kew is not prepared to tolerate any further procrastination on this project. As we have consistently informed the Ministry funding is immediately available to commence installation on a rolling budget basis. Alternatively, and if required, funding for total installation would be pursued through appropriate funding sources.*[178]

Thus, it is clear that the State of Victoria was on notice from KRS management of the risk to the residents at KRS. Not only was it aware of the risk but as is pointed out by the MFB:

> *(i) It was apparent or should have been apparent to the State of Victoria that there was a serious risk that a fire might occur at [KRS] and that were a fire to occur it would be very hazardous to life.*
>
> *(ii) The fire safety system at KRS was inadequate having regard to the degree and nature of the risk that a fire endangering life would occur at the institution and the State of Victoria appreciated or should have appreciated that this was so.*[179]

It could also be legitimately argued that the State was on notice of problems with the fire safety system at KRS from the 1986 MFB reports.

The Reply of the State of Victoria also examines the distinction between '*fire safety risk'* and *'likelihood'* of fire, and states that the Villamanta Legal Service in its submission has *'misconceived the advice given concerning fire safety risks with the risk of fire'*.[180] The comment is made that

176 State of Victoria Submission in Reply, p. 232, para. 6.1.

177 State of Victoria Submission in Reply, p. 246, para. 6.33.

178 Exhibit 234 'JT12'.

179 MFB Submission, p. 66, para. 134.

180 State of Victoria Submission in Reply, p. 232, para. 6.1.

there is no reference to the fact that ULA found the risk of fire *'relatively low'*.[181] The State's submission goes on to say:

> *As the OPA note, at page 156 of its submission, "the report reached a curious finding that the fire record of Kew and other evidence pointed to the risk of fire and danger to life and property as being relatively low" (OPA, p.65). No suggestion was made to any witness from KRS or DHS during the Inquest that it was known that there was a likelihood of fire. The focus at the Inquest, as it should have been, was upon the adequacy of the existing fire protection system and the extent to which it was known that it was inadequate. DHS, from the outset of the Inquest, presented oral and documentary evidence detailing the extent of its knowledge of the deficiencies in the system. DHS made no secret of the fact that officers at KRS recognised those inadequacies and the extent of the risk posed to residents.*[182]

The State's Submission examines the evaluation by Villamata Legal Service of the 11 years of fires at KRS (see Appendix 2.7 to the Findings – 'Villamanta Legal Service Summary of Recent Fires at KRS'). It states that Villamanta acknowledged that the:

> *fires varied in severity and probable cause, most of them being of a domestic nature arising in a kitchen setting ... Of particular significance is the fact that the vast majority of fires occurred in the kitchen with most of the balance of the fires being outdoors. Most of the fires are either the result of an electrical fault or burning food. Based on this analysis, VLS has submitted that because there were 38 fires at Kew between 1991 and 1996, 25 of which related to burning food fires could properly be described as a constant part of life at Kew. Whilst it is recognised that one ought not to underestimate the risk of potential fires commencing in a kitchen setting, the vast majority of the MFB's attendances were in relation to smoke given off from burning food. Furthermore, these attendances would have likely reinforced the perception at KRS that the existing detector system was operating effectively.*[183]

The State's Submission states that the evidence *'does not disclose whether KRS undertook any review or assessment of these fire incidents or whether any record was kept by KRS of attendances by the MFB. These incidents set out in the MFB reports do not support the proposition that the likelihood of fire at KRS was high. Furthermore, any knowledge based upon such incidents would not be that of DHS but its predecessors and the State of Victoria'*.[184]

However, such matters would be within the knowledge of KRS management. Indeed sound management would question the regular attendance of the MFB, and would seek to determine the level of risk from fire in view of the number of attendances of the Brigade. That the submission states that the evidence *'does not disclose whether KRS undertook any review or assessment of these fire incidents or whether any record was kept by KRS of attendances by the MFB'* is puzzling. Either KRS did not undertake a review, did not keep records (when it should have) or such a process was undertaken and the inquest has not been provided with the information. With the level of cooperationevident during the inquest, the latter explanation would seem unlikely.

The strength of the argument against the likelihood of fire must be seriously questioned because of the reported incidents of fire at KRS and the evidence of Ms. McCartin. While, as the State suggests,

181 State of Victoria Submission in Reply, p. 232, para. 6.1, referring to Exhibit 143 – the ULA Report, p. 17.

182 State of Victoria Submission in Reply, p. 233, para. 6.1.

183 State of Victoria Submission in Reply, pp. 233-234, para. 6.2. See Appendix 10.2 to the Villamanta Legal Service Submission which provides a useful analysis of the MFB fire reports.

184 State of Victoria Submission in Reply, p. 234, para. 6.3.

there must be some caution on the severity of the documented fire incidents, those along with McCartin's evidence suggest that there was a likelihood of fire at KRS:

> *Ms. Dixon: So in fact it appears there were two incidents with fires in wardrobes in the couple of years preceding the fire in 1996?*
>
> *Ms. McCartin: Yes*
>
> *Question: No doubt in hindsight those sort of incidents could have escalated into something very serious?*
>
> *Answer: If they had not been intercepted?*
>
> *Question: If they hadn't been able to be located, found and extinguished by staff?*
>
> *Answer: Yes, that could have escalated.*[185]

Apparently, at least one of those fires occurred after ULA delivered its report.

The fire reports and consultants' surveys, when aggregated, show that adequate warnings as to the inadequacies in the fire safety systems were given to KRS and its respective managing departments over several years. The warnings ranged from the technical hardware problems to issues that should have been addressed by management, such as staffing levels, reconvening of the Fire Safety Committe, conduct of fire drills and training in evacuation procedures. In addition, the coronial recommendations were but examples of warnings to government agencies with a role in public safety of the need to examine modern technology to provide counter-measures to fire. They also serve to illustrate, by example, failures in our risk management systems. In this instance, the coronial inquests cited have direct bearing on how our society manages fire risk and the disabled. It is also clear that the government and some of its agencies were warning KRS of the potential to improve fire safety with the installation of smoke detectors. Ministerial directives on safety relating to public buildings had been delivered.

There is an identified failure to draw together the many reports and recommendations dealing with the KRS fire issue. Sound management would dictate a process of review of the many reports and recommendations to globally consider whether the problems have been addressed or not. The level of attention paid by management to the recommendations from the various reports will be considered in the next Part.

In the final analysis, ten years of cumulative warnings about risk is too long to wait for work to be completed. A myriad of reported inadequacies with the fire safety and management systems at KRS had not been fixed by the time of the fire (although significant work on the alarm and sprinkler system was weeks off completion). The State of Victoria, through successive governments and a number of departments, has failed the nine deceased residents at the KRS complex.

185 Transcript, p. 6851.

PART 3 MANAGEMENT OF RISK AND SYSTEM DEFICIENCIES

This Part draws together many of the issues associated with advice from consultants and work by independent contractors on the fire alarm system at KRS. It sets out to show how the State of Victoria through its agents DHS/KRS contributed to the deaths of the nine victims by not providing adequate interim fire safety measures or management solutions to protect residents on the night of the fire.

Throughout this Part various deficiencies will be considered. Some of the the State of Victoria's responses to the shortcomings will be assessed in the light of the well-recognised risk. It will be seen that there is an identified failure to draw together the many reports and recommendations dealing with the KRS fire issue. Sound management would dictate a process of review of the many reports and recommendations to globally consider whether or not the problems have been addressed. This was not done.

The role of contractors and consultants is also considered in the light of a potential to contribute to the fire and/or deaths.

3.1 KRS'S FIRE SAFETY SYSTEMS: A LOCAL MANAGEMENT PERSPECTIVE

HISTORICAL OVERVIEW OF KRS MANAGEMENT RESPONSE

Any examination of the response to fire safety at KRS must consider the context of significant changes in the way our community managed care of persons with intellectually disability. As discussed earlier in the Findings, the recent direction is to emphasise the rights of the intellectually disabled to lead as normal a life as possible.[1]

The development of fire safety systems at KRS can be traced in detail through many fire brigade and consultants' reports from 1968 to late 1994.[2] However, from the late 1980s, the history of improvements and shortcomings can be seen by examining the evidence of Messrs John Taylor and Srini Vasan who worked at KRS during this time. Taylor was the Facilities and Services Manager and Vasan the Maintenance Manager. Vasan was a Marine Engineer by qualification.

Mr Taylor's statement commences with a discussion of the 1986 MFB 'Fire Protection Report'. By the time Taylor arrived at KRS in 1988, most of the minor works proposed by the 1986 MFB Report had evidently been implemented. Taylor was left to implement the major works. He first wrote in September 1988 to the Ministry of Housing and Construction expressing concern. It appears that in early 1989 telephone contact was made between Chief Fire Officer K. Warburton and Taylor. Taylor wrote a letter to Warburton on 23 February 1989, in which, after referring to the conversation and the Brigade's report no. 86/2214, he said (in part):

> *Recommendation No. I: Upgrade the existing domestic/fire main to ringed fire main only. Action: This project has been estimated to cost $670,000 and has been submitted to the Department of Community Services for inclusion on the Major Works Program.*

1 See generally State of Victoria's Submission in Reply, pp. 1-6; Public Advocate's Submission, pp. 166-174.

2 See discussion in the Findings in **PART 2 Knowledge of Risk and System Deficiencies 2.2 MFB Reports, Consultants' Surveys, Inquests and Departmental Directives.**

Recommendation No. 2: All fire and safety equipment to be maintained, mounted and indicated.

Action: All equipment is maintained by your service division. All equipment is currently undergoing review and luminous paint is to be used for indication purposes. Contact has been made with the Commonwealth Fire Board in this regard and strategies are in place to ensure all equipment is appropriately marked.

Recommendation No. 3: Upgrading the existing system of automatic fire alarms.

Action: A meeting of senior staff from the Ministry of Housing and Construction and ourselves was held on Monday, 20 February to discuss our dissatisfaction at the progress of adequately addressing this recommendation.

Recommendation: The Ministry has agreed to:

1. Give Kew Cottages its No. 1 priority.

2. Provide a master plan by the week ending 10 March including strategies and time frames for total project completion.

3. Immediately instruct its officers to organise the connection of any unconnected alarm manual call points.[3]

Mr Taylor also commented on another recommendation of significance in the most recent fire:

Recommendation No.5: Provision of remote controlled mechanism to simultaneously unsecure all exit doors to 'locked units'.

Action: The Department of Community Services has requested the Ministry of Housing and Construction to comment and make recommendations on your 1986 report. Their report has been completed and we are waiting for it to be forwarded to Kew. This recommendation will be addressed in their report'.[In addition a new fire indicator board was being installed at Administration].[4]

It is significant that, when referring to the MFB letter in his statement, Mr Taylor remarks that he '*expressed dissatisfaction at the progress in addressing these recommendations*'.[5]

Mr Taylor wrote to the Ministry of Housing & Construction on the issue of emergency/exit lighting. Funds were made available in April 1989 for replacement of the fire indicator panel. In 1988-89 and 1989-90, Taylor sought funds for the upgrade of the fire prevention system. He explained that he:

wrote to the Works & Services Division of the Department requiring urgent action in respect to the MFB report of 1986. Whilst the Works & Services Division of the Department had agreed in principle with the project, the budget had only been allocated on a rolling basis.[6]

In about April 1990, after correspondence between Mr Taylor and the Ministry of Housing & Construction, the Department of Management and Budget agreed to allocate $600 000 (over a two-year period) for the upgrade. During the same period, a further amount of $750 000 was made available for the upgrade of the fire ring main. In spite of the allocation these funds were not used

3 Note: Recommendation No. 4 deals with egress from Units 21, 22, 23 and 24, and funding of $100 000 was made available.

4 Exhibit 159 'JT4' – Mr Taylor's statement.

5 Exhibit 159, p. 2.

6 Exhibit 159, p. 2.

in 1990. During this time correspondence dealing with concerns about the number of false alarms continued between KRS and the MFB.

Towards the end of 1990, Mr Taylor prepared a prioritised list of capital works projects for inclusion in the Department's 1991-1994 three-year forward look program to be submitted to Treasury in March/April 1991. In February 1991, Taylor wrote to the Department's Works and Property Manager *'listing the upgrade of the fire protection system as the primary and critical project'*.[7] In late December 1991, Major Capital Works priorities for 1992-1995 were submitted by Taylor to the Department. Taylor said that:

> *[a]gain the upgrade of the fire protection system was listed as the primary critical project followed by the upgrade of the domestic water main to enable the fire protection system to conform to Australian standards.*[8]

A memorandum from the Director of Facilities and Administrative Services (Department of Community Services) to Taylor showed that the Department's Major Capital Works priorities for the purpose of Treasury budget allocation placed the upgrade of the fire protection system and the fire ring main as two of the Department's critical works. [9]

When the Lumley Report was being prepared in 1992, Mr Taylor stated that he recalled '*advising those compiling information for the Lumley report that we were aware that the fire prevention system was inadequate and that there were submissions for funding an upgrade of the system and the Ministry of Planning was being pressed to approve them'*.[10]

In 1992 no funds were made available. Another list setting out the major works (fire upgrade/ring main) was forwarded by Taylor to the Department. After the amalgamation of the Departments of Health with Community Services in 1992, a budget allowance was made for the upgrade. At this stage Dibben visited KRS for the purpose of preparing his report. Taylor thought that the Department of Planning & Development would do the work for the upgrade. However, he stated that '*I was never provided with any report from Dibben or advised as to any conclusions that he had reached'*.[11] Further, Mr Vasan stated that, during 1993, Dibben attended at KRS for the purpose of conducting a fire safety review. Vasan stated that, prior to the fire, he was not aware of the fact that Dibben had prepared a report.[12]

In early 1993, Mr Taylor allocated about $50 000 from the annual maintenance budget to install hard-wired smoke detectors. This decision resulted from a *'Departmental state wide directive that smoke detectors should be installed in such premises'*.[13] Some 285 hard-wired smoke detectors were installed by Fire Fighting Enterprises (FFE). They were connected to the existing thermal system, fire indicator panels and the MFB.[14]

In late 1993, Mr Taylor '*first learned that the Capital Management Branch of the Department would manage the fire prevention upgrade'*.[15] Mr Savona of CMB directed that a Project Control Group be formed for the tendering process for the audit and implementation. Evidently, Capital Management required that '*there be a comprehensive fire prevention audit to provide the basis*

7 Exhibit 159, p. 4.

8 Exhibit 159, p. 4.

9 Exhibit 159 – Memorandum – dated May 1992, p. 5.

10 Exhibit 159, p. 5.

11 Exhibit 159, p. 6.

12 Exhibit 176, para. 7.

13 Exhibit 176, para. 7; see also Exhibit 159, p. 6.

14 Exhibit 159, p. 6.

15 Exhibit 159, p. 6.

upon which the fire safety system would be improved'.[16] Mr Taylor clearly recognised the need for '*interim measures'*. On 16 December 1993, he wrote to Savona advising '*that KRS wished to introduce interim protection equipment pending the installation of the new system'*.[17] Taylor also undertook a review of the existing fire prevention system in each building. He was concerned about the absence of local alarms as he had *'become aware that all but seven units would only learn of an alarm as a result of advice from the administration block and the arrival of the MFB'*.[18]

In his statement Mr Vasan described that, in early 1993, there were discussions between Taylor and Savona (Capital Management Branch, Department of Health & Community Services) about a proposal to install local alarms to all units (some units already had local alarms). Evidently, KRS consulted Mr Daryl Knight, who arranged for Mr Ken Howie of Wormalds to quote on a system. As to the quotation (dated 22 March 1993), Vasan said that it:

> *stated that the alarm proposed was not approved by the MFB and was, in fact, designed specifically for KRS and accordingly would require MFB dispensation, the reason being the alarm did not have battery back-up. Mr Taylor and I thought the system proposed was inappropriate because of the lack of battery back-up.*[19]

Further quotations were sought from FFE, Wormalds and Jonkar. However, the work was not proceeded with as CMB had decided to fund:

> *a comprehensive upgrade of the fire prevention system. ... It was resolved to defer the decision on the three quotations until a fire consultant was appointed who would provide advice as to the appropriate local alarm system which would be integrated within the overall upgrade.*[20]

Mr Taylor commented that the report to the Project Control Group by ULA indicated that '*it was not viable to install an interim local alarm system because of the prohibitive cost'*.[21]

Mr Vasan explained that tenders were called for the fire safety upgrade in January 1994. During the interview process of five companies that were short-listed, questions were asked about 'Interim' solutions. After ULA was commissioned, a consultants meeting was convened between Scientific Services Laboratory (SSL), Savona, Taylor, Vasan and ULA. Apparently, the installation of local alarms (on an interim basis) was discussed. An interim low cost alarm measure was to be investigated by Mr Russell Cooper of SSL. Several low cost options were produced. However, KRS were advised by ULA and SSL that '*no appropriate interim measure could be recommended'*.[22]

It was recognised that the Department could not manage the upgrade because the cost of the works was in excess of $250 000. Accordingly, the Office of Building was engaged to assist. That officer was Mr Bill Mitchell, who became a member of the Project Control Group.[23]

On the appointment of the successful company to undertake the works, Mr Taylor said:

> *Wormald became the successful tenderer for the upgrade of the fire prevention system as theirs was the lowest tender price. Because their price was substantially in excess of the*

16 Exhibit 159, p. 7.

17 Exhibit 159, p. 7.

18 Exhibit 159, p. 14.

19 Exhibit 176, para. 8.

20 Exhibit 176, para. 8.

21 Exhibit 159, p. 15.

22 Exhibit 176, para. 9.

23 Exhibit 176, pp. 7-8.

funds allocated to KRS for the project it was necessary for Mr Mitchell to re-negotiate the cost of the works with Wormald. The PCG adopted a recommendation by Mr Lai modifying the original specifications and a report was prepared on modifications to the upgrade to bring it within budget.[24]

In a prepared statement, Mr Vasan related the history of the maintenance contract with Jonkar, saying that, although all documentation was forwarded by Jonkar to the Department of Planning and Development (DPD), copies of reports of services were rendered to KRS.

Evidently, the Fire Safety Committee (FSC) at KRS had been reactivated in 1992 at the direction of Mr Taylor. The FSC met from June 1992 until July 1993. The available minutes of the meetings were for the period after 27 October 1992 until 7 July 1993. In September 1992, the FSC first saw the Lumley Report. Vasan stated that Taylor:

directed the FSC to address, where possible, the report's recommendations. Minutes of meetings dated 15 September 1992 and 27 October 1992 detail the response of the FSC to a number of the Lumley recommendations.[25]

However, in mid-1993 as three of the original FSC members were unable to participate further, no further meetings of the committee were convened. Vasan continued to deal with any fire prevention issues. Taylor viewed the cessation of the committee in 1993 thus: *'once the committee had addressed the issue of upgrading the fire safety manual the committee ceased'*.[26] In addition, although staff ran fire drills, the FSC was not provided with the results. Evidently, an evacuation plan was developed for each unit, and plans of unit lay-out and fire jackets were provided.

As a result of the criticisms in the ULA Report on the 'ad hoc' approach to the installation of smoke detectors, KRS left the upgrade to the consultants. Mr Vasan stated that Unit 31 underwent renovations in late 1993 followed by Unit 30 in 1994. After the renovations to Unit 31, the area later to be described as Flat E comprised seven (7) bedrooms, which comprised the total sleeping accommodation for Unit 31. Jonkar was directed by Vasan to install smoke detectors in the newly renovated Flat E. Jonkar was to determine the number and location. According to Jonkar's invoice dated 29 December 1993, ten smoke detectors and one thermal detector were installed in Flat E. Although the Jonkar invoice was dated December 1993, Mr Vasan had observed that the:

detectors were installed in approximately July/August 1993 in the bedrooms and passage of Flat E.[27]

Following the renovations to Unit 30, Jonkar installed smoke detectors in the bedrooms and corridors of Flat B.

After the installation of smoke detectors in the renovated Units 30 and 31, Jonkar and the MFB attended following false alarms. Mr Vasan stated:

On some occasions Jonkar replaced smoke detectors with heat detectors where it became evident they had been installed in an inappropriate position such as a kitchen. To my knowledge, at no stage were any smoke detectors in Flat E bedrooms replaced with heat detectors.[28]

Jonkar provided Mr Vasan with various reports from 1993 until the fire. Vasan did not forward those reports to BSA.

24 Exhibit 159, p. 8.

25 Exhibit 176, para. 6.

26 Exhibit 176, p. 13.

27 Exhibit 176, para. 11.

28 Exhibit 176, para. 8.

In October 1995, Units 30 and 31 were amalgamated to form Unit 30/31. From May to October 1995, further renovations divided Unit 31 into Flats C, D and E. According to Mr Vasan, on the basis of the advice of ULA hard-wired smoke detectors were not installed in the bedrooms of Flats C and D. This area remained protected by the existing thermal and BGA systems. In June 1995, at the direction of Mr Gary Radler, three (3) domestic smoke alarms were installed in Unit 30/31.

During the renovations in October 1995, Mr Vasan noticed that a smoke detector in the kitchen of Flat E was inappropriately located. Jonkar was requested to attend and replace the smoke detector with a thermal. This resulted in the replacement of a number of smoke detectors with thermals in the kitchen area. Also one of the smoke detectors removed replaced a thermal in a Flat D bedroom.

Mr Vasan concluded his statement by saying:

> *I understood Unit 30/31 was protected by the old fire protection system ... (and) ... all bedrooms of Flat E were protected by smoke detectors, hardwired to the fire indicator panel ... If it be the case that the smoke detector was not working because of the upgrade or had been replaced by Jonkar or Wormald, I was not advised as to this.*[29]

It is worthy of note that Mr Vasan commented that from the time he commenced working at KRS (in 1990) he was *'aware that John Taylor was seeking to upgrade the fire prevention system but had not been allocated funds to do so'*.[30]

3.2 UPGRADE MANAGEMENT

3.2.1 ROLE OF THE PROJECT CONTROL GROUP AND THE PRINCIPAL CONSULTANT (ULA)

The *'Kew Training Centre Fire Safety Upgrade – Consultant Brief, Fire Audit and Schematic Design'* set the tone for the work of the Project Control Group (PCG). The brief provided that the *'delegated authority of the Department of Health and Community Services will be vested in the Project Control Group (PCG)'*.[31] The PCG was made up of two representatives from KRS and two from Health & Community Services, and was to act for the Principal Consultant, which was to prepare the fire audit and be *'responsible for the appointment of appropriate sub-consultants in their team to analyse and design the works'*.[32] The Principal Consultant was also required to liaise with other consultants to provide schematic design; arrange meetings of the project design team; liaise with the KRS Project Officer; prepare costs; attend at least three PCG meetings; and provide a briefing for staff.[33]

It is significant that the PCG had representatives from the KRS management area who possessed corporate knowledge of the inadequacies of the system. CMB were also represented by an experienced project manager who had undertaken other fire upgrades. The Project Manager – Mr Savona – was aware of the issues raised in the Dibben Report.

3.2.2 CONTRACT TO UPGRADE THE FIRE SYSTEM AND WORMALD'S ROLE

Wormald undertook the upgrade of fire services at KRS. Work commenced in October 1995. The contract specifications with Wormald provided that *'the engineering office shall be notified*

29 Exhibit 176, para. 28.

30 Exhibit 176, para. 7.

31 Exhibit 162, para. 5.

32 Exhibit 162, para. 5.

33 Exhibit 162, para. 6.

immediately of any actions or occurrence which may reduce the fire safety of the complex or any part thereof'.[34] Thus Wormald had a responsibility to advise of '*any actions or occurrence*' affecting fire safety. This was not a broad role to advise of '*any deficiency'*, as is suggested by the State of Victoria when considering this point as applied to potential problems with the existing wiring. It could not be said that Wormald was responsible for a *defacto* 'building by building' audit of the existing fire safety system. Rather, it was there to fix the problems with a well-identified inadequate fire safety system by installing a new system. Even accepting an arguably broader construction under the contract specifications, there are limits to Wormald's responsibility to identify problems.

Wormald commenced work in Unit 31 some 12 days after Jonkar's last attendance at Flat E when a smoke detector generated an alarm. From the date Wormald commenced work in the unit until it left on 17 January 1996, following the discovery of asbestos in the roof, there were no false alarms. There is no evidence of any other identified problem with the existing system at this time.

Wormald was conducting the upgrade work because the fire safety system had been recognised as being inadequate by a number of reports spanning some years. There were fire engineers regularly on site and involved in meetings with Wormald. KRS had the daily services of a maintenance engineer. The existing system utilised a combination of old thermal and smoke detector technology. Thermal detectors were fitted in bedrooms of many of the residential units that Wormald had already completed. Thermal detectors were also fitted in the bedrooms of most of the flats in Building 37. The system was maintained by Jonkar which had been the case for a few years. These were facts that all on site presumably knew.

If, as is argued by the State of Victoria, that Flat E had smoke detectors fitted in the bedrooms, there was little cause for Wormald to be concerned. If this was not the case and thermals were in the bedrooms of Flat E, then this was a common, and presumably, well-recognised problem throughout the complex. This was the problem that was about to be addressed by the installation of a new system. It was not a problem about which Wormald could reasonably have been expected to advise KRS regularly. It was a problem that any outsider would have expected KRS management to be aware. It was a problem in the midst of being fixed by Wormald.

It is in this context that the State of Victoria and the Public Advocate seek to cast blame on Wormald:

> *It is clear that if smoke detectors were present in Unit 30/31 there were not enough, they were wrongly positioned or they were inactive or faulty. For this the culpability fundamentally rests with Jonkar Industries, those responsible for maintaining the system and with Wormald Fire Systems, those responsible for and at the relevant time working on the new installations. The defective quality of the Unit must have been apparent to both companies if they had been acting competently, professionally and in accordance with their duty of care to the residents. Between them a safe residential environment could have been orchestrated, and should have been orchestrated. Its absence leaves both culpable on any fair evaluation of the state of Unit 30/31 at the time of the fire. What appears to have occurred is an unsatisfactory co-ordination of responsibilities and functions. For this both Jonkars and Wormald Fire Systems are responsible but so too is the Department of Planning and Development for having failed to supervise the renovation works conducted by Wormald Fire Systems and the maintenance by Jonkar.*[35]

The difficulty with these submissions is that there is no evidence that Wormald was contracted to regularly check the soon-to-be-defunct system. KRS had a contractor to do that work. It also had a qualified maintenance engineer. The failure to have Jonkar/Wormald involved in coordinating the

34 State of Victoria's Submission, p. 196, para. 1.104.

35 Public Advocate's Submission, pp. 157-158.

upgrade planning and/or on the PCG is a failure of management – not of Wormald. Put at its highest, the suggestion that '*Wormald had a contractual responsibility to advise KRS of the non-operation of the smoke detector system'*[36] is not supported by any evidence of a failure in the existing system during Wormald's short tenure in Building 37, Unit 31. The question whether Wormald's work interfered with operation of the existing system is a different issue and will be dealt with later.

In this regard the State of Victoria suggests that conduct by Wormald '*remains a reasonable competing hypothesis to explain the systems failure'*. It further suggests that had *'the matter been explored in a timely fashion this hypothesis could have been excluded or demonstrated to be a likely cause of the systems failure'*.[37] In more strongly worded submissions, the State of Victoria is critical of a part it suggested that Wormald played in the investigation.[38] These allegations will be dealt with in the Findings in **PART 4 Survival and the Detection System on 8 April 1996 4.1 State of the Fire Alarm System on 8 April 1996.**

3.2.3 PROGRESS FOLLOWING THE ULA AUDIT

A number of buildings at KRS were completed and connected to the system before the fire in Building 37. Completion of the system included installation of addressable smoke alarms and connection of the sprinkler system. The units connected included Units 1, 7/8, 11, 13/14, 15/16, 17/18, 19/20, 21, 25, Gieger and O'Shea. Of this group, the first units connected were 15/16 (on 1 December 1995) and the last (prior to the fire) was Unit 11 (on 7 March 1996). The Units not connected were: 3, 4, 5, 9, 22, 26/27, 28/29, 30/31 and Smorgan. Evidently, Units 5 and 29 were undergoing renovations which caused some additional delay for connection.

3.3 FUNDING DELAYS IN ADDRESSING FIRE SAFETY AT KRS

3.3.1 INTRODUCTION

The history of delays and difficulties with funding the various fire safety initiatives at KRS is considered in some depth in the Submissions of the Villamanta Legal Service and the Parents' Association.[39] A broader and more circumspect view is provided in the Reply for the State of Victoria.[40] While funding must be considered in light of the financial difficulties facing the State of Victoria in the first half of the 1990s, a brief examination of the history shows that significant funds were promised. For some reason, the opportunity was either lost or not proceeded with until the most recent upgrade. However, in 1993, some limited KRS funds were used to upgrade the detection system partially to smoke detectors.

Funding applications were managed through DHS's Capital Management Branch (CMB). Although management must be considered in the light of other priorities and demands on funding, the State of Victoria had a clear responsibility for the safety of the intellectually disabled residents at KRS.

The Dibben Report was delivered to CMB. In its draft form it was obviously a major document dealing with significant fire safety issues. After delivery to CMB, it did not see the light of day. The response by CMB was to order a fire safety audit (by ULA) which put back action for at least a further 12 months. The reason for undertaking another report, according to Mr Savona, was:

36 State of Victoria's Submission in Reply, p. 486, para. 1.79, quoting the Office of Public Advocate's Submission.

37 State of Victoria's Submission, p. 192, para. 1.90.

38 See in particular State of Victoria's Submission, pp. 191-192; Submission in Reply, pp. 482-487.

39 See Villamanta Legal Service Submission, pp. 11-12; Parents' Association Submission, pp. 4-12.

40 State of Victoria Submission in Reply, pp. 255-310.

and still is CMB policy and practice where capital funds are sought and being used for major fire services upgrades that a Fire Safety Audit and Fire Risk Analysis be completed by a qualified fire engineer as a pre-requisite.[41]

A study of CMB's approach to the Dibben Report provides key clues to its view of the urgency of work to upgrade the fire safety system. On any view it did not give Dibben the attention it deserved. Had Dibben been distributed to those who needed it most – KRS and ULA – the management of the upgrade might well have been different. Unfortunately, we will never know.[42]

The Dibben Report is instructive for another reason. The MFB in its Submission notes that Dibben recommended a sprinkler system. The report was commissioned by Mr Edgar:

in February 1992 when Mr Edgar was managing capital works projects at the then Community Services Victoria (Exhibit 262 at par 14). The procedure then in place in relation to capital works contemplated that the Dibben report would be obtained and its recommendations implemented. According to Mr Edgar's evidence, he would have followed this procedure when he received the Dibben report in August 1993 (see T6103-5).[43]

However, by this time:

Community Services Victoria, and the then Health Department Victoria, were amalgamated to form the Department of Health and Community Services (Exhibit 214 at 1). The Capital Management Branch of the newly merged department became responsible for the management of capital works. Mr Savona, as an officer who was technically qualified and senior to Mr Edgar, determined that the Dibben report was "technically flawed" or "redundant".[44]

Thus, submits Counsel for the MFB, with the merger of the departments 12 valuable months were lost. However, it considers that '*this delay has itself to be seen against the fact that the MFB and KRS staff had been pressing for an upgrade of the fire safety system at KRS for many years prior even to the provision of the Dibben report in February 1993'*.[45] However, the delay in obtaining a further report (ULA) must also be seen in the light of the fact that Mr Dibben[46] considered that an additional evaluation of the existing system would be necessary. The Dibben Report was regarded as a qualitative assessment and the next step was for a quantified approach.

But the State of Victoria in its Reply has admitted that:

[t]he delay in the obtaining of a fund allocation from the time that Mr Taylor first submitted the upgrade as a priority capital works project should be a matter of justifiable concern. The State of Victoria accepts much of the criticism that has been raised by various parties concerning this delay. The functioning of government and the bureaucratic process accounts for much of this delay. The State of Victoria recognises that the constructive criticism that has been raised will lead to the reform of some of these processes.[47]

However, it is also argued that delay does not amount to contribution to the cause of death. In order to consider the relevance of the delay issue and to put the bureaucratic processes in context, it is necessary to examine briefly the history of the moves towards the upgrade. By doing so, the

41 Exhibit 214.

42 See discussion in the Findings in **PART 2 Knowledge of Risk and System Deficiencies 2.2 MFB Reports, Consultants' Surveys, Inquests and Departmental Directives.**

43 MFB Submission, pp. 114-115, para. 202.

44 MFB Submission, pp. 114-115, para. 202.

45 MFB Submission, p. 115, para. 203.

46 Transcript, p. 2873.

47 State of Victoria's Submission in Reply, pp. 261-262, para. 83.

commitment of KRS management, such as Messrs Taylor and Vasan, can be placed into context. It is noted that there were obvious (and documented) tensions between management at KRS and at Departmental level over the issue of fire safety and upgrades.

3.3.2 ATTEMPTS AND SUCCESSES

There were several attempts made to secure funding for an upgrade of the fire safety system by Mr Taylor at KRS. As discussed in the Findings in **3.1 KRS's Fire Safety Systems: A Local Management Perspective,** these requests for funds were being made from as early as 1986.

Following the 1986 MFB Report, Mr Dobson, Manager at KRS, sent a memorandum to the Manager Property and Services Branch, CSV. He noted that improvements in fire services *'could cost many hundreds of thousands of dollars'* and wrote:

> *I have categorised the work under the following headings and suggest that each be carried out as major works project as funds become available. I should emphasise however that some of this work be carried out this financial year.*
>
> *Work to be done in order of priority is as follows:-*
>
> *1.Testing and upgrading of fire alarm system to all buildings within the Centre.*
>
> *2.The provision of mimic panels and upgrading of indicator panels for Fire Brigade direction when attending alarm calls.*
>
> *3.Repair/replace or extension of fire water mains to provide an adequate ringed water reticulation system.*
>
> *4.Fitting of internal hose reels in buildings identified in the report.*
>
> *It is envisaged that works relating to upgrading of fire extinguishers, boxes for external hydrants and an additional exit door in unit 10 can be handled at a local level together with appropriate signs. It would be hoped that item 1 could be processed immediately and that the second project completed this financial year. The administrative procedure for the remaining two projects should commence this financial year with the aim to complete at least item 3 in the 1987/88 financial year.*[48]

Once Mr Taylor came onto the scene in 1988, he also delivered significant warnings about the fire risk. In a letter to the MFB dated 23 August 1989, he advised that the ring fire main works had been submitted to CSV for inclusion in the Major Works Program. In relation to fire alarms he noted:

> *Recommended (sic) No. 3 Upgrading the existing system of automatic fire alarms.*
>
> *Action: a meeting of senior staff from the Administrative Housing and Construction and ourselves was held on Monday, 20 February to discuss our dissatisfaction at the progress of adequately addressing this recommendation.*
>
> *Recommendation.*
>
> *The Ministry has agreed to:*
>
> *1. Give Kew Cottages its No. 1 priority.*
>
> *2. Provide a master plan by the week ending 10 March including strategies and time frames for total project completion. ...* [49]

48 Exhibit 159 'JT1'.

49 Exhibit 159 'JT4' .

By August 1989, Taylor had by letter advised a senior manager in the Ministry of Housing and Construction that, in case of fire, the residents at KRS '*would be placed at enormous risk in the event of fire'*. This letter (previously partially referred to) expresses what can only be regarded as dissatisfaction with the progress of improvements to the fire safety systems at KRS. Notably, he points to the fact that there are no plans indicating fire safety coverage. In part the letter states:

> *During discussions it was intimated that the M.H.C. may not have the resources to meet this time frame. The management of Kew regard this project as a matter of the highest priority and are prepared to work with a consultant to ensure early completion.*
>
> *A consultancy under the supervision of the Ministry and Kew would be acceptable.*
>
> *Thomas Walker & Sons Pty. Ltd. have also been requested to undertake an assessment of all buildings – approx sixty-five (65) to determine the actual protection of each. There does not exist either at M.H.C. or Kew Cottages any master plans that contain this basic information.*
>
> *You should be aware that over 750 intellectually disabled people are accommodated at this Centre. Many of these people have profound physical and intellectual disabilities and would be placed at enormous risk in the event of a fire.*
>
> *The management of Kew is not prepared to tolerate any further procrastination on this project. As we have consistently informed the Ministry funding is immediately available to commence installation on a rolling budget basis. Alternatively, and if required, funding for total installation would be pursued through appropriate funding sources.*
>
> *Your early advice would be appreciated.*[50]

That dissatisfaction was well founded. Unfortunately, the delays upon which the concern was so obviously built were to continue for a number of years.

Apparently, by April 1990, the Department of Management and Budget decided to allocate a total of $1 350 000 over two years for works on the project. The period was to commence at the beginning of the 1990/91 financial year. The funding was provided for the upgrade of both the fire prevention system and the ring fire main.[51] A letter from the Mr Jackson, Chief Executive Officer of CSV, to the President of the MFB Board dated 1 May 1990 confirms the allocation:

> *Kew Cottages management has for a considerable time been addressing the problem of the inadequacy of our fire protection system.*
>
> *Mr J. Taylor the Facilities and Support Services Manager has convened three meetings of officers of your Service, fire protection and maintenance contractors and Ministry of Housing and Construction Engineers to address issues around the design of a totally new system that conforms with current Australian Standards ...*
>
> *Budget submissions based on these discussions to the Department of Management and Budget have succeeded in funding of $600,000 being allocated to Kew over two years commencing 1990/91 – 1991/92.*
>
> *Further budget submissions have also resulted in the allocation of $750,000 over the same period to upgrade the ring fire main.*[52]

50 Exhibit 159 'JT12' – Letter dated 7 August 1989.

51 Exhibit 159.

52 Exhibit 159 'JT16'.

Despite approval of these funds by the Department of Management and Budget, no actual money was made available during 1990. Mr Edgar gave evidence that '*Mr Jackson was in error when he put those figures into his report to the brigade'*.[53] The records reveal that the project was not listed in capital works programs.[54] There was no explanation given to the inquest for the failure to continue with this line of funding.

The submission from the Parents' Association on this area of confusion is telling:

> *Mr Edgar says that the budgetary documentation to which he has access does not record such approval. Although Mr Taylor was re-examined immediately following Mr Edgar's evidence, discrepancy between the evidence is unexplained. At best, it can be said inter-departmental communication was so bad KRS wrongly believed it had funding and both KRS and the MFB were misled. At worst, funding was obtained but simply not utilised for reasons which are unexplained.*[55]

It is hard not to agree.

Other work on the fire safety system had been undertaken.[56] Mr Taylor continued with fire prevention work within the limits allowed by his own local budget allocation. In 1993, some smoke detectors were installed in buildings at KRS.[57] By the end of 1990 and 1991, Mr Taylor submitted a prioritised list of major capital works required at KRS. This was part of the Department's three-year forward plan. On 7 February 1991, he also sought funds for the upgrade from the Department's Works and Property Manager (which was unsuccessful).[58]

Mr Taylor was notified in May 1992 that upgrade of the fire protection system and the ring fire main was identified by the Department as critical works requiring funding. It was approved by the Department, costed at $850 000 and submitted to Treasury.[59] Apparently, this line of funding was delayed by the State election in 1992. Following a change of government in October 1992, the Departments of Community Services Victoria and the Health Department were amalgamated into the Department of Health and Community Services (later to become DHS). Evidently, in December 1992, a freeze was placed on all capital works expenditure in excess of $800 000.[60] In October 1993, the $850 000 for the fire safety upgrade at KRS was approved by Treasury. An allocation of $250 000 was to be spent in the 1993/94 financial year with the balance to be spent in the next year.

It is significant that four years had elapsed since Taylor had written to the Ministry of Housing and Construction advising of the 'enormous risk' which the residents of KRS faced in the event of a fire. On the delay, the Villamanta Legal Service stated in its Submission that it:

> *acknowledges the persistence of Mr Taylor in attempting to secure funds to deal with the "enormous risk" in which the residents of KRS lived. We submit, however, that it is unreasonable that there be a delay of four years from the explicit acknowledgment of that risk and the allocation of funds to deal with it. The residents of KRS were obviously unable take their own measures to better ensure their safety. They were totally reliant on the Department. This created an undelegable duty of care for the Department. We note that neither the State of Victoria in general, nor the Department of Community Services*

53 Transcript, p. 6246.

54 Transcript, p. 6346.

55 Parents' Association Submission, p. 7, para. 17.

56 Fire escapes to some units and a main fire indicator panel: see Exhibit 159 'JT16' – Jackson's letter.

57 Exhibit 159.

58 Exhibit 159.

59 Exhibit 262 – Mr Edgar's statement, para. 12.

60 Exhibit 262 – Mr Edgar's statement, para. 12.

Victoria (later the Department of Health and Community Services) in particular, had established procedures to ensure swift attention to matters affecting the safety of people to whom it owed this duty.[61]

In 1993 Dibben, Winn and Newton visited KRS for the purpose of preparing a report on the fire safety systems. Following the issue of this report to CMB, it remained in the file. An examination of the reasons for this action is to be found in the Findings in **Part 2 Knowledge of Risk and System Deficiencies 2.2.3 Consultants' Surveys and Their Use.** The Parents' Association submitted that this showed a failure '*to appreciate the risk at KRS*' and the '*reports provided direct criticism of observed practices at KRS and direct suggestions as to a whole series of management issues'*.[62]

The Parents' Association has identified a number of areas where management processes at CMB were of concern, once funds for the upgrade were allocated. It was suggested that the evidence of Mr Edgar and Mr Savona established:

(a) the Capital Management Branch ("CMB") did not treat the works as critical, ie. works which must be implemented in the budget period allocated (T6234, 6236-8, 6267 and 6550-2);

(b) CMB treated the project as no more urgent than other projects which had funding (T6244-5 and 6550-2);

(c) CMB did not regard the works as involving issues of serious life safety at KRS (T6244-5,6548 and 6550-2);

(d) CMB lost approximately 1 year in the effective implementation of the works because of inter-departmental amalgamation (T6265 and 6575);

(e) CMB did not regard the Dibben Report as establishing a critical need for upgrade works. Indeed Mr Savona did not accept Mr Dibben had in substance "got it right" (T 6552-7, 6565, 6608-9 and 6624-5);

(f) CMB effectively gave no weight at all to the Dibben Report (T 6552, 6557 and 6607);

(g) CMB prepared a consultant's brief for Fire Audit and schematic design in January 1994 and proceeded with the audit process without any acceptance at that time of a need for fast tracking (T 6552, 6558 and 6566).

In evidence, Mr Savona considered that the Dibben Report did not present the case for urgency:

Mr Osborn: Don't you think that the Dibben Report demonstrated to anyone who read it that this wasn't such a case of due process, it was a case for urgent measures?

Mr Savona: No.[63]

An examination of the transcript evidence lends weight to each of the allegations made in the Parents' Association Submission. Each of the named witnesses left the impression of a lack of urgency and a devaluing of the Dibben Report. It is also argued by the State of Victoria that the issue must be seen in the context of the need for management to prioritise a large number of projects within procedural and budgetary constraints.[64] But, as indicated, a delay of ten years is too long when a significant number of warnings have been given as to the risk of fire and the

61 Villamanta Legal Service Submission, p. 12.

62 Parents' Association Submission, p. 10, para. 25.

63 Parents' Association Submission, pp. 8, 22. See Transcript, p. 6558.

64 See, for example, a number of projects listed in the State of Victoria's Submission in Reply, pp. 272-274, para. 8.20 (10). See also pp. 270-272 for some of the constraints.

consequences in the light of an inadequate system. However, in this context, it is also the failure to distribute Dibben which is crucial. The Dibben Report was a risk management tool that should have been used – not shelved.

In addition, on a number of occasions, the funding documentation describes the work as *'critical'*.[65] *'Critical'* was defined as a project '*which must proceed in 1991/92'*.[66] It was distinguished from projects which were '*urgent*', i.e.*'projects which should proceed in 1991/92 if funds are available'*.[67] The work was accepted on a short list of statewide critical works by May 1992.[68] Following the 1992 election, there was a freeze on certain levels of capital works. However, once the funds were eventually allocated in 1993, CMB apparently did not regard the upgrade as '*urgent*', even after the issue of the ULA Report where '*[u]rgent'* was defined as *'works which must be implemented immediately'*. CMB (Mr Savona) did not accept that '*[u]rgent'* in the ULA Report meant '*urgent'*:

> *Mr Osborn: Why do you say that, when he uses the word "urgent" he didn't mean urgent?*
>
> *Mr Savona: It is in regards to being the same as a priority one project, which means that as funds come along that is the first project to be addressed.*[69]

After the failure of the audit to provide interim solutions, CMB did not accept that the works had become urgent:

> *Mr Osborn: Mr Savona, you have just said you were involved with the audit process. Now it is the audit process that produces a ranking of urgent or high or some less a priority, isn't it?*
>
> *Mr Savona: The audit and risk analysis process, yes.*
>
> *Question: Before that process is complete you are told that there is no feasible interim solution and that the best solution is to bring in the upgrade as soon as possible; is that right?*
>
> *Answer: Yes, that is correct.*
>
> *Question: But, despite that, you still tell us that when you got Mr Lai's report you did not regard the word urgent as meaning urgent; to be done immediately; is that right?*
>
> *Answer: I regarded that that was a ranking of requirements that had been specified within the report and that they were to be given the first priority. It is standard throughout all the reports that wording.*
>
> *Question: First priority to you does not mean urgent, to be done immediately? Is that right?*
>
> *Answer: First priority means that it is to be considered first in regards to the ranking of funding for projects.*[70]

A difference in definitions between 'financial' and 'risk' managers may explain this divergence of views. However, what is clear is that, even though the funds had been appropriately allocated, a long and identified risk was allowed to continue through a management process which, on one view, did not appear to consider the urgency of the upgrade. By its very nature, the process was bureaucratic and resulted in some delays.

65 Exhibit 159 'JT19'.

66 Exhibit 159 'JT18', p. 2.

67 Exhibit 159 'JT18', p. 2.

68 Exhibit 159 'JT 21', p. 5.

69 Transcript, p. 6563.

70 Transcript, p. 6567.

It was submitted by the State of Victoria in its Reply that:

> *the submissions made ... have consistently failed to take into account that one of Capital Management Branch's responsibilities was its role in applying for and allocating funding for a wide range of capital works across the State of Victoria. Fundamental to the bureaucratic process was the designation of the works into one of a number of categories by each complex seeking funding and further prioritisation by the Department when seeking an allocation from Treasury.*[71]

It was further said that:

> *[t]he State of Victoria submits that if criticism is to be made of Capital Management or its officers for failing to recognise the degree of risk to which residents at KRS were exposed, it must be to the substance of the information that they were provided that one would need to look.*[72]

Clearly, the effect of any delay on the eventual outcome is a different issue to that of managing the risk. It is not the issue of delay in dealing with the Dibben Report but in the failure to deal adequately with the wide range of fire safety issues raised in that report. This failure rests with CMB.

Other aspects of delay are examined in detail in the State's Reply. It says that there was '*no delay between funding approval and ULA audit*' in that the time lines are as follows:

> *1. November 1993 – CMB initial meeting with KRS.*
>
> *2. January 1994 – consultant brief completed.*
>
> *3. January 1994 – expressions of interest advertised.*
>
> *4. February 1994 – close of submissions, February 1994 – final submissions requested.*
>
> *5. March 1994 – Interviews.*
>
> *6. June 1994 – PCG meeting etc.*[73]

Further, it is stated that:

> *[t]his was the required process at the time as specified by government regulations and CMB guidelines, viz. Project Development and Construction Management Act – Ministerial Direction No. 1, Financial Management Act – Treasury Regulation and Code of Practice for the Building and Construction Industry.*[74]

Given the identified times for the various steps, there does not appear to be an unreasonable delay.

The aspect of times for the tender for the upgrade works was also examined in the State's Reply. Evidently, there was a delay of one month in the tendering process while '*several issues were being negotiated between DHS and Department of Planning and Development. These included establishing the roles and responsibilities of the Construction Manager, the cost of the services, the process required for the management of the site and the tender process'*.[75] From January to May 1995, ULA was involved in the design of the upgrade for the tender. The bulk of the work was completed in March and the balance in May. The State of Victoria submits that there '*is no basis for finding that there was any unreasonable delay*'.[76] Clearly, this argument is soundly based: there

71 State of Victoria's Submission in Reply, p. 304, para. 8.82.

72 State of Victoria's Submission in Reply, p. 304, para. 8.82.

73 State of Victoria's Submissions in Reply, p. 305, para. 8.85.

74 State of Victoria's Submissions in Reply, p. 305, para. 8.85.

75 State of Victoria's Submissions in Reply, p. 307, para. 8.89.

76 State of Victoria's Submissions in Reply, p. 307, para. 8.90.

appears to be no *unreasonable* delay. But it also must be remembered that there was delay, and the fire engineers at ULA had placed a shorter time frame on the project. The likelihood of the project being 'fast-tracked' was not considered. Apparently, there was no fast-tracking procedure available.

The State's Reply points to other areas where delay has occurred. For example, it suggests that CMB's role was to ensure that:

> *government and departmental policy and process was strictly adhered to. Part of the delay ensued because of the uncertainty as to what entities would actually undertake the contractual obligations of the upgrade. Under the new government it had been contemplated that entities such as KRS would enter into their own contracts for major capital works. This did not eventuate. It became necessary for DHS to engage the Office of Building of the then Department of Planning and Development to supervise the upgrade. This delayed the upgrade process.*[77]

The issue of delay can clearly be seen in the State of Victoria's overview of the times:

> *September – October 1994: The process of appointing the consultant for the design of the fire safety upgrade ...*
>
> *November – December 1994: Ministerial approval and formal appointment of the consultants.*
>
> *January – May 1995: Design of the upgrade by ULA, appointment of the Office of Building as construction manager, PCG meetings dealing with the staging of works ...*
>
> *July – September 1995: Renegotiation of Wormald tender to bring it within budget.*[78]

In 1992, once Treasury work commenced on the identification of fire risk in complexes operated by the government, the management of the process leading to the 1995 upgrade could not be said to be fraught with delay. However, although some delay has been identified, on balance, it could not be said to be unreasonable. There were obvious bureaucratic, risk assessment/advice, budgetary, approval, advertising and tender processes to be managed. Time is accounted for in all of these processes. That is not to say that potential for improvement in responses should be ignored in cases where fire safety issues have been identified.[79]

But it is only when looking at the overall picture of ten years of warnings about fire risk at KRS that the delays become significant. For individual periods over that long time, explanations may be put forward by particular agencies. It is in the totality of delay that the problem lies. It is in this area that the State of Victoria must take responsibility.

3.4 DELAY RELATED TO ASBESTOS REMOVAL

Asbestos had been identified as being in some of the buildings at KRS well before the contract for the fire systems upgrade was let.[80] The responsibility for removal and making the work areas safe

77 State of Victoria's Submissions in Reply, pp. 307-308, para. 8.91

78 State of Victoria's Submissions in Reply, pp. 309-310, para. 8.96. See in particular para. 20 (Savona); Exhibit 258.20 – Mitchell statement, paras. 8-9; Howie statement, paras. 3-4 (minutes of PCG); Howie statement, p. 2; Exhibit 258.20 – Mitchell statement, p. 12.

79 See, for example, State of Victoria's Submissions in Reply, p. 306, para. 8.86, where procedure has '*now been modified for fire safety projects allowing a quicker appointment of fire engineers from a register of prequalified fire engineers. This process negates the need to advertise for expressions of interest and permitting an appointment to be made from detailed submission*.'

80 For example, on 5 August 1993, Michaud Constructions provided a quotation for removal of the asbestos cement roof.

rested with KRS. Apparently, it was considered that this had been done. Unfortunately, further asbestos was discovered during work on the roof spaces in Building 37, Unit 31.

When Mr Mitchell of BSA took over responsibility of the Superintendent for the upgrade project in September 1995, he raised the issue of the presence of asbestos at a PCG meeting. Evidently, at that meeting, Mr Savona of CMB stated that:

> *if there was a problem with asbestos, then the contractors could surface mount the conduit to avoid disrupting any asbestos material, That is, the relevant conduit and works could be placed below the ceiling levels.*[81]

After discussions between ULA and Wormald, the view was formed that surface mounting was not an appropriate strategy to deal with the asbestos issue. It may have further disturbed asbestos sheeting and created a safety problem for residents at KRS. Following further discussion with Mr Savona's replacement on the PCG, Mr Bentivoglio, it was decided to obtain an asbestos audit *'to determine the extent of the problem and to put in place a strategy to deal with the asbestos by removing it'*.[82] BSA was requested to submit a fee proposal to manage the removal of asbestos. Apparently, the proposal was not accepted by DHS which decided to manage the issue of asbestos removal itself. The asbestos audit was arranged by DHS to be undertaken by Kilpatrick & Associates Pty Ltd. Mitchell met on site with Kilpatrick and Wormald:

> *to ensure that* [Wormald] *specified every area in which it was proposed that work be undertaken, so that Kilpatricks could look in and assess those areas. This exercise initially took one day, and took place prior to* [Wormald] *being awarded the contract in an effort to assist with price negotiations.*[83]

Asbestos clearance certificates were to be supplied to Wormald before they commenced work in specific units. Apparently, the Kilpatrick's audit generally described where asbestos was located in a unit. Mitchell said that *'[n]otwithstanding the provision of asbestos clearance certificates,* [Wormald] *found as they worked through the Units, the presence of asbestos in a number of the areas in which they were working in the Units'*.[84] The problems with the identification of asbestos may have resulted from *'difficulty in undertaking a thorough inspection until the specific work areas were cleaned of fibreglass insulation ready for commencement of the work. The specific points at which cutting or drilling was to occur may not have been known when the audit took place'*.[85]

Following the ongoing discovery of asbestos, DHS decided to obtain the services of Azcor Consultants Pty Ltd to identify and monitor sites. The problems still continued, and Noel Arnold & Associates were engaged. An accelerated strategy was adopted whereby all the insulating material in the roof spaces was removed.

Wormald had a responsibility for the health and safety of its employees under the terms of the *Occupational Health and Safety Act* 1985 (Vic). In addition, the Union (CEPU) was apparently concerned for the safety of its members working at the site. On the morning of 17 January 1996, Wormald staff were ordered to cease work on Units 30/31 because asbestos was discovered in the roof space. It is noted that the identification of asbestos in Unit 30/31 was notwithstanding '*asbestos clearance certificates by Azcor'* dated 7 September 1995.[86] It is also noted that on 21 February

81 Exhibit 258 – Mr Mitchell's statement, p. 3, para. 9.

82 Exhibit 258 – Mr Mitchell's statement, p. 4, para. 10.

83 Exhibit 258 – Mr Mitchell's statement, p. 5, para. 14.

84 Exhibit 258 – Mr Mitchell's statement, p. 6, para. 16.

85 Exhibit 258 – Mr Mitchell's statement, p. 6, para. 17.

86 Exhibit 258 – Mr Mitchell's statement, p. 8, para. 24.

Mr Mitchell informed Wormald not '*to go into any ceiling spaces until further notice. In so informing* [Wormald]*, I was aware that there was other work that* [Wormald] *could undertake outside the ceiling spaces whilst the asbestos was being removed'*.[87] That work included such areas as mounting alarm panels, break-glass alarms and emergency lights, and laying sprinkler pipes and the communication loop.

On 14 March 1996, CEPU directed that its members not work in the roof spaces of all the units at KRS because of the unresolved asbestos issue. Other work had continued on site. All other work by Wormald (apart from the roof spaces) was effectively completed by 28 March. This only left the work in all roof spaces to complete the connection of the alarm and sprinkler systems. That work was not done for Units 30/31.

On 2 April 1996, the Building Services Agency, Office of Building, granted an extension for completion of the upgrade to Wormald. The extension was for 29 days, moving the completion date from 17 April to 31 May 1996. The extension of time related to the asbestos removal issue.

The State of Victoria's Reply comments that '*there is no evidence to suggest that the consideration of asbestos issues accounted for any delay during the period between ULA and SSL completing its audit and Wormald commencing on site'*.[88] After Wormald commenced work on site, delays obviously occurred, but Wormald was not responsible for those delays.

Once asbestos is identified, as this case has aptly demonstrated, there is potential for delay. In the future, it is clear that, where fire safety issues are involved, the management of asbestos, its identification and removal, should be in train well before the contractual arrangements are finalised. While there may be some practical difficulties (as this case demonstrates), dealing promptly with asbestos becomes part and parcel of early management during this type of fire upgrade. The Villamanta Legal Service in its Submission suggested that:

> *[t]he asbestos issue was known to Kew for years through a number of audits. In early 1994 Mr Mitchell raised the issue with Mr Savona. The foreseeability of these issues meant they could have been planned for and dealt with in a strategic way, rather than haphazardly and reactively. VLS submits there is little attempt to fast-track these issues and a failure to treat to the upgrade as urgent.*[89]

It could not be said that the identification of the asbestos issue went smoothly and did not result in some delay.

3.5 FORCE OF ARGUMENT ON DELAY

Once the need for an upgrade was recognised and management work towards that goal commenced through a process of audit reports, tendering, dealing with budgetary issues and general project control, it was inevitable that there would be some delays. Although accepting some criticism on delay, the State of Victoria in its Reply submits that a properly operating smoke detector system would have resulted in the nine lives lost being saved. Thus, it argues, that delay played no part in the cause of the deaths.[90] Clearly, had the existing system been operating correctly, it was likely that the nine residents' lives would have been saved. This is persuasive on one level but does not excuse inadequacies in the system.

87 Exhibit 258 – Mr Mitchell's statement, p. 7, para. 21.

88 State of Victoria Submission in Reply, p. 310, para. 8.97.

89 Villamanta Legal Service Submission, p. 57, para. 6.9.

90 See State of Victoria Submission in Reply, pp. 262-264, paras. 8.4-8.6.

On one level, it is reasonable to argue, irrespective of the frustration accompanying delays in the work leading to the upgrade, that there was a system in place which, if either properly maintained or audited, would have not resulted in loss of life. However, even if it operated correctly, it may not have permitted sufficient time to change significantly the outcome as far as damage to the building was concerned. It is likely that a sprinkler system would have positively affected that outcome. Unfortunately, the maintenance system was not audited; thus, there can be no confidence that it did operate effectively.

The argument on delay applies both to both funding and asbestos issues. It must also be recognised that irrespective of the views on delay commitment to, and work on, an upgrade was underway. Again, however, a totality of ten years for the fixing of the identified problems with the fire safety system is far too long. For that the State of Victoria through successive governments and its agencies must bear responsibility.

One of the real issues to be considered is the management of the well-recognised risk in the time before the full installation of the fire safety system at KRS. The long history of MFB reports, consultants' audits or surveys and inquests are significant in that they draw clear attention to the many deficiencies that needed to be managed in the interim. They were not managed.

In conclusion, the Reply of the State of Victoria best summarises the delays in the past and looks to the future when it says:

> *The delay in the obtaining of a fund allocation from the time that Mr Taylor first submitted the upgrade as a priority capital works project should be a matter of justifiable concern. The State of Victoria accepts much of the criticism that has been raised by various parties concerning this delay. The functioning of government and the bureaucratic process accounts for much of this delay. The State of Victoria recognises that the constructive criticism that has been raised will lead to the reform of some of these processes.*[91]

3.6 MAINTENANCE OF FIRE ALARM SYSTEMS AT KRS AND BUILDING 37

3.6.1 INTRODUCTION: CONTRACT

The annual maintenance of KRS's fire alarms was undertaken by a contractor engaged by the Victorian Government 'Building Services Agency' (BSA) of the Department of Infrastructure (formerly the Department of Public Works and later Department of Planning). The Department of Infrastructure acted as agent for DHS. Annually, tenders were invited for the maintenance contract. Jonkar Industries Pty Ltd were the successful tenderer as from 1991.

When the original contract was let, a document was provided with the specifications for the work. Records of comparative tenders between 1992 to 1996 show that Jonkar was not the lowest tender for some of the relevant periods. It should be noted that Jonkar was the only tenderer for 1992/93 and 1995/96. Apparently, the tender process for the maintenance contract was carried out in accordance with the appropriate Ministerial Direction (No.1 – effective from 22 May 1995). It is understood that a '*reference check was carried out by BSA to verify Jonkar's technical competence*'. However, the file relating to the reference checks cannot be located.[92]

91 State of Victoria Submissions in Reply, pp. 261-262, para. 83.

92 Exhibit 258.57 – Mr Lee's statement, p. 4, paras. 17-18 (Lee is the Associate Director, BSA).

Jonkar Industries is a small fire protection service firm registered with the MFB and the Country Fire Authority (CFA) as an installer and maintainer of fire alarm systems. At the time of the fire, it operated with two partners and three service personnel. The business was operated from the partners' home in Box Hill.

Each yearly maintenance agreement was to be carried out in accordance with the original specification. That specification provided the work was to be executed:

> *in an efficient manner by competent tradesmen, in accordance to AS 1670-83, 1851-86 P.W.D. REFERENCE SPECIFICATION FOR 'MAINTENANCE AND ALTERATION'. Contractor is to comply with all regulations of authorities concerned and in such a manner so as not to inconvenience the normal running of building and to the entire satisfaction of the superintendent or his representative.*[93]

Under the heading 'Procedure', the contract specifies '*1. All work and trades involved in this contract are to be carried out by a competent tradesman to the accepted trade practices and to the satisfaction of the Public Works'*. The contract specification includes a number of headings.[94]

A letter dated 17 July 1992 to Jonkar from the Ministry of Housing and Construction, Victoria, states that '*[a]ll work must be to the satisfaction of the Superintending Officer*'.[95] This letter allows for the possibility of the quality of the work being reviewed by the Superintending Officer.

It has been argued by BSA that there was no provision for audit within the maintenance contract.[96]

3.6.2 AUSTRALIAN STANDARDS AND COMPLIANCE WITH SPECIFICATIONS

The evidence established that Jonkar failed to comply with its contractual obligations in significant areas. Deficiencies ranged from the failure to supply adequate plans to interfering with the integrity of the alarm system by changing smoke detectors to thermals.

AUSTRALIAN STANDARDS

The Australian Standards were called up in the specifications. Generally, Australian Standards are to be viewed as a guide. However, as they are called up in the specification for maintenance, they become part of the contractual arrangements between the parties. As is put by the MFB in its Submission:

> *It is axiomatic that the requirements of these standards are laid down in order to ensure that detection and alarm systems operate as intended to give the earliest possible alarm in case of fire. Any departure from the requirements of the standard may result in the system being compromised. The standards represent minimum industry practice and are often, as in the present case, required to be followed as a matter of contractual obligation. Moreover the standards are often called up by relevant building legislation, regulation and codes.*[97]

The relevant standard is AS 1851.86, which sets out requirements for regular maintenance of automatic fire detection and alarm systems that are '*designed and installed in accordance with*

93 Exhibit 176 'SV2' – Mr Vasan's statement.

94 For example, Description; Execution of Work; Visit to Site; Contract; Verification of Service; Log Book Recording; Payment; Extent of Work (Monthly Tests, Annual Tests, Heat Tests); Break Down Service Calls; Variations; Identification of Company.

95 Exhibit 176 'SV2' – Mr Vasan's statement.

96 See discussion in the Findings in **PART 3 Management of Risk and Systems Deficiencies 3.6.3 Maintenance and 'Audit'.**

97 MFB Submission, p. 138, para. 237.

AS1670'.[98] In addition, regular maintenance includes inspection and testing. Minimum requirements are that 20 per cent of thermal and 50 per cent of the smoke detection system be tested annually. On a positive note, KRS specified that 100 per cent of the detection system be tested by the maintenance contractor each year.

The maintenance contract provided that Jonkar was to execute the work *'in an efficient manner by competent tradesmen, in accordance to AS 1670-83'*, which sets out requirements for *'the design, installation, and commissioning of automatic fire detection and alarm systems comprising components complying with the requirements of the appropriate product Standards'*.[99]

Counsel for Jonkar in its Submission argued that its client was faced with maintaining a fire detection and alarm system that did not comply with AS 1670. The submission correctly put that, when assessing the performance of Jonkar against the maintenance requirements of AS 1851, the standard clearly applies to systems *'designed and installed in accordance with AS1670'*.[100] Obviously, Jonkar did not install the system; it came in at a late stage to manage the maintenance. Persuasively, the submission put that *'the overwhelming evidence produced at the inquest was that the fire detection system was antiquated and, in many respects, inadequate'*.[101] This fact was no doubt obvious to all involved in the inquest and had resulted in the work to upgrade the system. It was argued that Jonkar maintained the system on a limited budget so that it was a properly functioning system. However, when considering the effect of this submission, it is necessary to examine the extent of Jonkar's failures. The responses of KRS to information provided by Jonkar also need to be considered.

MAINTENANCE COMPLIANCE

There were a significant number of areas where the relevant standards were not maintained by Jonkar. These were admitted by Mr L. Neicho and one of his employees, Mr S. Moore.

When questioned during the inquest, Mr L. Neicho agreed that he understood from the outset that Jonkar was to carry out the maintenance in accordance with AS 1851 and 1670. He agreed with Counsel for the MFB that during the currency of the maintenance contract there was no agreement that the Standards were not to be followed.[102] He also agreed that he did not communicate deficiencies to the 'department'. The evidence on this point is as follows:

> *Mr Bell: Mr Neicho, could you tell me how is it that you came to adopt the practice of just not telling the department about particular failings of the system as you (indistinct); how did that happen?*
>
> *Answer: Bad housekeeping.*
>
> *Question: You think you fell into bad habits is that what you're trying to say?*
>
> *Answer: Bad habits on recording things, but not bad habits in maintaining the system.*
>
> *Question: So you would say that though you failed to follow the standards, and though you failed to report particular areas of non-compliance, at all times you saw that the system – you saw to it that the system operated safely?*
>
> *Answer: Operated safely, that's true.*[103]

98 Exhibit 167 – AS 1851, clause 1.1.

99 Exhibit 167 – AS 1670, clause 1.1.

100 Jonkar Submission, p. 6, para. A6.

101 Jonkar Submission, p. 6, para. A6.

102 Transcript, pp. 4481-4482, 4483.

103 Transcript, p. 4483.

The deficiencies in the system of maintenance performed at KRS were numerous. Some are illustrated in the evidence of Mr S. Moore. The relevant passage is as follows:

Mr Bell: Mr Moore, the dual testing that you do, and I repeat annual, requires you to look at the placement and condition of detectors in order to see that they comply with codes?

Answer: Yes.

Question: And in the case of the Kew Cottages contract, it was required that that be done in the case of all the detectors?

Answer: Yes.

Question: Yes. And it is a requirement of AS1670, isn't it, that a clear space of at least 300 mm radius shall be maintained from the detector, that is around the detector, in order just to be clear of anything for a radius of 300 mm?

Answer: That's correct.

Question: Also 1670 requires that 'the detectors shall not be installed closer than 400 mm to any air supply opening'?

Answer: That's correct.

Question: There is to be a space of at least 400 mm from such an opening to the detector?

Answer: That's correct.

Question: Coming back to the maintenance standard, 1851, that standard requires you to see whether or not a detector has an excessive disposition of dust or a coating of paint?

Answer: That's correct.

Question: Any coating of paint would register a fail against that standard, would it not?...

Question: Yes. Any coating of paint – if it were painted at all, it would fail that standard?

Answer: Yes.

Mr Gleeson: Could Mr Bell indicate the standard?

Mr Bell: Certainly. 3.3B. ...

Mr Bell: I'm looking at 1851 at the moment (To Witness) Mr Moore, you were out there with me this morning, and a group of persons inspecting the premises?

Answer: That's correct.

Question: I noticed a large number of detectors that are at least now painted. Did you notice those?

Answer: Yes, I did.

Question: From my observation of the paint and the condition and age of it, it would seem to me that they would certainly have been painted in July of last year when you did the tests; is that so?

Answer: That's correct.

Question: I also noticed, and would you agree, that there were about 50 per cent of the detectors that were in that condition?

Answer: That sounds correct, yes. Sounds about right.

Question: I also noticed at least some detectors that were very close to fluorescent light housings. Did you notice those also?

Answer: Yes, I did.

Question: Certainly a distance not 300 mm from such a housing?

Answer: Yes, that's correct.

Question: Mr Moore, I also noticed when I was there a number of detectors that were placed very close to exhaust air supply openings. Do you know what I'm talking about?

Answer: Yes.

Question: Those holes with slats over them, circular slats over them. They were (indistinct) air supply opening, and I observed some detectors that were placed close to those? Did you see any of those, Mr Moore?

Answer: I remember observing one in that condition, yes. ...

Question: Standard 1670 requires that detectors shall not be installed closer to 400 mm from any air supply opening. I think I put that to you before?

Answer: You did, that's correct.

Question: Such a thing would register a fail against that standard, wouldn't it?

Answer: Yes, it would.

Question: Again, Mr Moore, in respect of the placement of detectors, I noticed some detectors that were placed near the edge of walls, that is at a point on the ceiling quite close to the wall?

Answer: Yes.

Question: Did you notice some of those also?

Answer: I do remember one, yes.

Question: At a distance not 300 mm from the comer?

Answer: That's correct.

Question: Being a non-complying detector, would you agree?

Answer: That's correct.

Question: I also saw some detectors that had damaged heads. Did you notice any of those? I mean indented ones?

Answer: I do recall seeing, again, one or two indented detectors.

Question: That's a matter that renders that detector non-complying, I suggest to you?

Answer: Yes.

Question: Mr Moore, the standard also requires, and I refer here to the maintenance standard 1851, that you, check for any building alterations, changes in the environment, or utilisation of the protected area, which would require modifications of the system. That's 3.3J?

Answer: That's correct.

Question: I suggest to you that in the case of detectors to which other objects have been placed too close, for example the situation where a fluorescent light base has been placed too close to a detector, that standard requires you to check for that, and to see to its correction; do you agree with that?

Answer: That's correct.

Question: 3.3L requires that in the log book you include details of detectors and (indistinct) points that do not pass the visual inspection or fail to operate satisfactorily, and notify the owner or his agent of any deficiencies with the installation? That is your responsibility, is it not?

Answer: That's correct. ...

Question: Yes. (To witness) Now, Mr Moore, I have in respect of the July 1995 test one document which I believe to be the only document that exists in relation to that test – – ?

Answer: Yes.

Question: – – – and that is the record of maintenance and test report, dated July 1995, which was, in fact, signed by Mr Neicho; do you know of the existence of any other document as regards to that test?

Answer: Only the documentation that was given to the department to Rob Stuart, I think it is, to clarify that the test had been completed.

Question: Now, I put to you, Mr Moore, a list of areas in which the existing system in Building 37, the very building at issue, is non-complying; – – –?

Answer: Yes.

Question:– – – did you in any log book register the non-compliance of the system in those respects?

Answer: No, I don't believe I did.

Question: Did you bring to the attention of KRS Mr Stuart, or anybody on behalf of the department, of those things?

Answer: Not of the department, no.

Question: It would appear, Mr Moore, that your failure to do those things would result in your test itself not being carried out in conformity with the Standards in 1851; would you agree with that?

Answer: Yes, I would.

Question: Can you give any explanation for that, Mr Moore?

Answer: I had discussions with my boss about this and I was told that when we took over the system all these deficiencies were there and that the funding wasn't available to rectify all of the defects at Kew Cottages, and for that reason we were just to make sure that all the detectors did operate and to test the system was operating and those things would have to be rectified as units were upgraded and rectified when the funding was available.

Question: Yes, I see. When did you have this conversation with your boss?

Answer: I believe we have had this conversation a few times. The first time would have been 93 to 94 when we were doing the annual testing. I couldn't give a specific date when we had the conversations.

Question: And would it be the case that in each of those years, that practice was followed?

Answer: Yes, (inaudible) the case.[104]

The State of Victoria in its Submission is also critical of Jonkar's performance under the contract in that it '*failed to maintain and test the fire detection system ... in a manner which ensured its proper operation was not compromised'*.[105] The submission conveniently lists the following areas where Jonkar breached its duties:

(1) Incorrectly placing detectors and/or failing to rectify the incorrect placement of detectors;

(2) Failing to perform a thorough visual inspection of detectors for factors that could adversely affect their functioning;

(3) Installing and/or failing to rectify the installation of an excessive number of detectors on Circuit 39;

(4) Failing to ascertain the status and verify the integrity of wiring in Unit 30/31 failing to inform BSA or KRS of any potential deficiencies as a result of faulty or aged wiring;

104 Transcript, p. 4131. See also the MFB Submission, pp. 140-142, which conveniently summarises the position.

105 State of Victoria Submission, p. 229, para. 1.214.

(5) Keeping poor records and inadequate plans;

(6) Insufficient training, instruction and supervision of Jonkar Staff.[106]

In the first three itemised deficiencies, the State's Submission suggests that neither BSA nor KRS were informed of problems. This lack of communication is also alleged in relation to the fourth point. Mr Moore's evidence supports this submission on items 1 and 2. It also lends weight to the poor records argument (item 5). When Moore raised the issue of deficiencies with L. Neicho, he was advised that funding was not available. Because of this response Moore was not properly supervised or advised of his duties by his employer (item 6).

Within the Submission on Jonkar's behalf on contribution is to be found the argument that the relevant government departments were well aware of the shortcomings. As the government was already advised by the Dibben or ULA reports and did not act, it is argued that '*[t]he court cannot presume that Government Departments would have acted if similar criticisms had been made by Jonkar'*.[107] This does not excuse Jonkar's failure to properly advise. As we have seen, staff at KRS did not have a copy of the Dibben Report. Regular reports from Jonkar (guided by the relevant Australian Standard) would probably have identified a large number of additional shortcomings.

Jonkar's Submission also puts that by April 1996 it:

> *had been maintaining and servicing the fire detection system at Kew Cottages for approximately 5 years. In that time, Jonkar had submitted numerous annual test reports. Jonkar did not receive a single complaint from KRS or any Government department. Nor did it receive any suggestions in relation to the manner in which it conducted the monthly or annual tests or generally maintained the system. The contract was renewed each year without comment. Jonkar was entitled to presume that its client was completely satisfied with its performance under the contract.*[108]

The failure to report on specific identified deficiencies is in direct breach of Jonkar's contract. The argument fails to appreciate that the client may not have known about specific problems which it could have rectified within the annual maintenance budget or through an application for additional funding.

Jonkar's Submission seeks to argue that it '*serviced and maintained the fire detection system at Kew Cottages in a competent manner'*. In support it makes reference to the fact that neither Messrs Vasan nor Stewart complained. Stewart stated that he was:

> *familiar with the work of Jonkar through a number of contracts which that company has with the BSA. I believe from my experience with Jonkar that they are a competent company who properly and effectively carry out their duties in a diligent manner. I have not in my experience with Jonkar had cause to have any concerns about their competence or performance. The improved performance of the fire alarm system at Kew Cottages confirms this opinion. I have also been satisfied that the liaison between Jonkar, the Metropolitan Fire Brigade and Kew Residential Services maintenance personnel has been effective in achieving proper maintenance and necessary rectification of the fire alarm system in a timely manner.*[109]

We now know that Mr Stewart was not in a position to make these comments as he was not auditing the maintenance contract, while Taylor and Vasan mistakenly thought Stewart was checking

106 State of Victoria's Submission, p. 230, para. 1.215.

107 Jonkar Submission, p. 7, para. B1.

108 Jonkar Submission, p. 8, para. B4.

109 Jonkar Submission, p. 4, para. A1 (Mr Stewart's statement, para. 11).

on the work of Jonkar. The submission also seeks to rely on the following: positive comments from Station Officer Kelly;[110] Dibben's remark in the report that '*no doubt these organisations are performing to an acceptable standard*'; and Mr Lai's evidence that (1) he saw no cause to criticise Jonkar in his report and (2) he did not discover any detector that failed to operate during his investigation.[111] Clearly, Mr L. Neicho was aware of a number of deficiencies in the system that he did not communicate to anyone at KRS or BSA. He was aware of those deficiencies as early as 93/94.[112]

On Jonkar's behalf it was put that '*Les Neicho, Skye Neicho, Stephen Moore and Travis Cox all gave evidence that the fire detection system at Kew Cottages was serviced and maintained substantially in accordance with Australian Standard 1851.8-1987*'.[113] This argument supporting compliance does not take into account either Moore's conversation with L. Neicho about funding for the system (and keeping it going) or Moore's own evidence to the inquest about compliance. It is not persuasive.

Jonkar was regularly changing smoke with thermal detectors especially during renovations. It was suggested that this practice was done on temporary basis and that the smoke detectors were replaced after the renovations were complete. This issue is discussed later in the Findings in P**ART 4 Survival and the Detection System on 8 April 1996 4.1 State of the Fire Alarm System on 8 April 1996.** In this context the MFB argued that the high incidence of false alarming led to:

> *inappropriate minimisation action, such as replacement of smoke detectors with thermal detectors. This occurred at KRS on a wide scale, and may well have been why the smoke detectors in the bedroom where the fire originated and elsewhere in Flat E were replaced with thermal detectors. KRS management were justifiably concerned about the high incidence of false alarms (see for example the evidence of Mr Taylor at T5484). The staff of Jonkar Industries were no doubt reacting to this concern when they changed a large number of smoke detectors to thermal detectors. Many of the changes were necessary because, for example, smoke detectors had been wrongly positioned in kitchens and bathrooms where they were found to false alarm.*[114]

The State's Submissions contain arguments as to how maintenance shortcomings may have affected the integrity of KRS's fire detection system in April 1996. These issues are further considered in the Findings in **PART 4 Survival and the Detection System on 8 April 1996 4.1 State of the Fire Alarm System on 8 April 1996.**

However, it is clear from the evidence of Mr Moore that L. Neicho was well aware as far back as 1993 that Jonkar was not complying with the terms of its maintenance contract. At no stage did Neicho raise his concerns about the state of the system or Jonkar's noncompliance with KRS or BSA. While the unsatisfactory state of the existing system and lack of funding have been put as an explanation, they cannot excuse the numerous deficiencies in the work practices of Jonkar which continued over several years.

3.6.3 MAINTENANCE AND 'AUDIT'

There was no system of audit of the fire alarm maintenance. The issue of audit of maintenance systems was raised well before the fire in the Lumley Report, the Department of Infrastructure's Dibben Report, the Umow Lai Fire Audit and in the Fabric Survey. Each of those documents was

110 Exhibit 17.

111 Jonkar Submission, pp. 4-5.

112 Mr L. Neicho's conversation with Mr Moore: see Transcript, p. 4131 et seq.

113 Jonkar Submission, p. 5, para. A5. Reliance for this submission was placed on the statements of Les Neicho; Stephen Moore; Skye Neicho; Travis Cox.

114 MFB Submission, p. 106, para. 188.

with Human Services in sufficient time to address the maintenance audit issues. Had effective audit been undertaken, a number of fire safety 'early warning' issues may well have been addressed by management at KRS. As already noted, even Mr Dibben considered that the performance of the maintenance contractor was being managed by DPD. It is worth repeating his comments in the supplementary statement:

> *4. I understood that the fire protection system at KRS was being maintained by a properly qualified contractor and that the Department of Planning and Development was responsible for the due performance of the contract. It was not my intent to recommend that staff at KRS undertake any of the maintenance contractor's tasks or the functions of the Department of Planning and Development in ensuring that the maintenance contractor discharged its duties.*[115]

Both DHS and BSA put a joint position to the inquest that BSA's role did not extend to quality auditing of the maintenance system.[116] But management at KRS also believed that BSA, who was overseeing the maintenance contract, also conducted an audit. Factually, this was not the case. The BSA contracts system meant that any 'audit' was the responsibility of the client (in this case KRS). However, the actual contracts do not provide any guidance in this area; in fact, they are ambiguous and may lead to the false conclusion that the work is being overseen.

The position of Messrs Taylor and Vasan can be effectively summarised by a series of questions flowing between Counsel for the Victorian Government and Mr Stewart:

> *Mr Redlich: But Mr Vasan and Mr Taylor have in substance, I'm not going to put the specifics to you, but Mr Taylor and Mr Vasan have said in substance, their understanding or assumption was, that you – you in relation to the Kew contract, were taking the responsibility for seeing that the contractor did everything that he was required to pursuant to these specifications. Does that surprise you?*
>
> *Answer: No.*
>
> *Question: You say, do you not, that had you the time that's what you would have done more effectively than you did?*
>
> *Answer: Yes.*[117]

Historically, an examination of letters attached to Mr Taylor's statement may partially explain reasons for this misunderstanding. The letter from Mr Jackson, Chief Executive Officer of CSV, to the President of the MFB Board dated 1 May 1990, confirming the allocation of funding in its penultimate paragraph, relates to maintenance. It also highlights the potential for problems with maintenance:

> *In regard to the maintenance of our system we have a maintenance agreement with Thos Walker & Sons Pty. Ltd. This contract is supervised by the Ministry of Housing and Construction. Mr Taylor has recently convened a meeting of these parties to address areas of concern expressed by MFB representative, Mr P. Parsons. These concerns have now been satisfactorily addressed.*[118]

The next letter in this range of correspondence between Jackson and the President of the MFB on this issue states:

> *As you are aware the management of Kew have for some time been advocating for funding to upgrade the system.*

115 Exhibit 296.

116 Transcript, p. 6257.

117 Transcript, p. 6677.

118 Exhibit 159 'JT16'.

Unfortunately the age of our system dictates the occurrence of a number of detector faults.

Your consideration is sought in exempting Kew Cottages from charges relating to false alarm calls.

Kew Cottages is quite prepared to reconvene a meeting of your representatives, the Ministry of Housing and Construction and Thos. Walker and Sons Pty. Ltd. to re-examine any problems. However it seems that the total replacement of the system is the only solution.[119]

From these documents it would appear (from KRS's perspective) that the Ministry of Housing and Construction was involved in some type of supervisory role – at least in 1990. Eventually, Jonkar took over the maintenance contract. However, no system of audit of the maintenance work was developed.

A statement was provided by Mr Vichai Lee, Associate Director of BSA. Mr Lee explained that BSA operated by delegation from the Secretary, Department of Infrastructure (pursuant to powers under sections 37 and 38 of the *Project Development and Construction Management Act* 1994). Evidently, BSA's role is to '*facilitate and manage public construction for departments and public bodies'*.[120] Mr Lee explained, in some detail, the various contractual arrangements between the Department of Human Services and the BSA. Under the heading 'Review of Contractor's Performance', Lee stated:

It is not routine in the public or private sector for the Superintendent to undertake a technical audit of contractors' work. To my knowledge, it is not usual for there to be a technical audit of a contractor's work in relation to minor works or maintenance contracts. By "technical audit" I mean the Superintendent inspecting works to assess compliance of the work with requirements such as Australian Standards, measurements, performance criteria or other technical qualifications. However there are a range of ways in which performance is verified.[121]

Mr Lee also suggested ways in which performance could be verified (i.e. Quality assurance systems or where '*services are being installed or maintained, it is common for the systems test to be produced and in some cases certified by an external body'*). However, he reiterated that it was not '*usual for the contract administrator to carry out audits of contractor's work'*.[122]

The role of the 'Superintendent' or contract administrator is described in Mr Lee's statement. Evidently, it is rare for the contract administrator's role to extend beyond determining and managing payment to '*technical auditing of a contractor's work'*. Further, '*standard form building contracts'* do not require the contact administrator to undertake technical audits of the contractors work. Lee cited by way of example a number of standard form contracts where technical audits are not required.[123]

According to Mr Lee, the 'Superintendent, BSA has complied with the industry practice'. In summary, the role of the Superintendent as to quality of the work is:

limited to ... prescribing the satisfactory level of quality to be achieved by the Contractor and requiring reported or identified defects to be rectified. The Superintendent's role does not extend further into auditing the technical details of the contractor's work.

119 Exhibit 159 'JT17' – letter dated 18 July 1990.

120 Exhibit 258.57, p. 2, para. 8.

121 Exhibit 258.57, p. 2, para. 8

122 Exhibit 258.57, pp. 3-4, para. 14.

123 Exhibit 258.57, pp. 5-6, para. 22. See standard form contracts – 'AS2124-1992'; 'NPWC3'; 'JCC-D'; 'SBW-2'.

> *The contractor is responsible for workmanship and having qualified tradesmen and supervisors.*[124]

Where auditing is required, the work is usually given to a Clerk of Works, Building Inspector or technical consultant. Evidently, '*BSA has not employed works inspectors for more than five years'*.

Mr Lee stated that the Jonkar contract (including standard Minor Works Conditions) provides that the Superintendent can *'determine the level of workmanship'*. If technical audit was necessary, and a Clerk of Works engaged, a separate fee over and above the nine per cent for documentation and contract administration would be required.[125]

Mr Robert Stewart, Project Officer, BSA, stated that he held the role of Superintendent for the annual maintenance contract. He had undertaken that role continuously for the last seven years. Stewart was of the view that he was responsible for *'the administration of payments, and processing of various claims under the contract'*. He visited KRS *'to check that the testing is being undertaken by the contractor as required'*. Stewart stated that when hevisited KRS:

> *for whatever purpose (whether related to the annual maintenance contract or for other unrelated works) I check the log book to ensure that it is being maintained. I have always found the log book to be present and properly maintained.*[126]

Mr Stewart recalled that there were a significant number of faults and problems at KRS before Jonkar obtained the maintenance contract in 1991. Stewart stated that Jonkar undertook significant work to rectify the problems, and *'[a]s a result of this the number of callouts and faults found in the system diminished, with a decrease in the cost of the contract and variations'*.[127] Mr Stewart was further satisfied that:

> *the liaison between Jonkar, the Metropolitan Fire Brigade and Kew Residential Services maintenance personnel has been effective in achieving proper maintenance and necessary rectification of the fire alarm system in a timely manner.*[128]

Unfortunately, a proper examination of the maintenance work undertaken by Jonkar does not justify this confidence.

It is noted (by Mr Lee) that the potential role of the Superintendent in the standard Minor Works Contract (as for Jonkar) to '*determine the level of workmanship'* has not been explained. Unfortunately, management at KRS believed that Mr Stewart of BSA was auditing Jonkar's maintenance.

After the close of evidence, solicitors for the BSA submitted an additional statement by Mr James Fox, Associate Director, BSA, touching on a number of issues raised in Stewart's evidence. Fox was Stewart's manager from 1993.Having read the transcript of Stewart's evidence, Fox expressed surprise at some of his answers as they were not consistent with comments or impressions given during their professional relationship nor were they consistent with BSA's practices and procedures.

Mr Fox deposed that Stewart's role changed in 1989 from inspector to Building Services Officer. During the time he was administering the upgrade works, he was required to attend KRS regularly and that '*it would usually be appropriate to attend the site once or twice a year'*. Evidently, at a meeting between Fox and Taylor (at Fox's office) in August 1993, there was some discussion about BSA's involvement at KRS. Fox stated that Taylor advised:

124 Exhibit 258.57, p. 6, paras. 23, 24.

125 Exhibit 258.57, p. 6, paras. 24-27.

126 Exhibit 281, p. 3, para. 8.

127 Exhibit 281, p. 4, para. 10.

128 Exhibit 281, p. 4, para. 11.

that although he had seen an improvement in the level of service from BSA in the preceding few months since I had been in charge at Dandenong, KRS would not be requiring the services generally of BSA for works at KRS as they had the appropriate expertise in-house at KRS and Mr Taylor had his own experience. I recall that he mentioned that there was an engineer at KRS. From that time on few, if any, new projects came to BSA's Dandenong office directly from KRS.[129]

Mr Taylor in a subsequent statement attached to the State of Victoria's Reply denies this conversation, reaffirming his belief that BSA were overseeing Jonkar's maintenance contract.[130] Also Mr Stewart, during his evidence, commented that he did not inform KRS staff that he would not be regularly attending at the complex.

Mr Fox further deposed that the reason for the annual maintenance contract remaining with BSA was because such works were centrally funded by the Department of Health and Community Services and BSA had access to that funding. Evidently, it was common for BSA to administer maintenance contracts with the client (KRS) determining the scope of additional work. Fox commented that:

[c]lients often add works to the basic maintenance required by the specification. BSA's role would then be primarily to pay the contractor when the client ordered the works and approved the payment. I believe that this is what happened on the Jonkar contract where between 75% and 85% of the work performed represented variations to the contract requested by KRS, either in response to MFB call-outs or upgrade works required by KRS. Unless the client requested an assessment or "report and estimate" or there was some dispute about the contractor's charge, it would not usually be necessary on such contracts to inspect the works before making the payments. It is common for clients to have a loose interpretation of the scope of the contract and add related works which they required.[131]

Mr Fox also stated that the new specification for maintenance contracts is performance-based and places a greater onus on the contractor. He also remarked that '*[a]uditing might be expected to decline with a performance based contract*'.[132] Fox confirmed the views of both Lee and Stewart that auditing was not part of the Superintendent's role. Compliance with Australian Standards was considered to be the contractor's responsibility and technical audit is not usual.

Mr Stewart's evidence on the roles of KRS and BSA highlights one of the crucial systems failures:

Ms. Dixon: ... The invoices that have been provided by Jonkar show that on at least 23 occasions smoke detectors were replaced with thermals during renovations, and that's clear just from the invoices. Was that something that you ever noticed or – ?

Answer: No, that was arranged through management at Kew Cottages to go on their annual maintenance contracts rather than on their building file.

Question: But did it ever come to your attention, reading those invoices, that this was happening and perhaps it wasn't the best way of dealing with renovations?

Answer: Well, they – it was their maintenance contract; they used to put on it whatever they liked with regards to whether they were doing an upgrade of a building or whether they were – it was just a broken detector.[133]

129 Exhibit 299, p. 3, para. 14.

130 State of Victoria Submission in Reply, attached to p. 590.

131 Exhibit 299, p. 3, para. 14.

132 Exhibit 299, p. 4, para. 19.

133 Transcript, p. 6670.

Clearly, senior staff at KRS were of the mistaken view that BSA was looking after maintenance compliance whereas the reverse the case. While Stewart appeared to be clear on the respective roles of the two Departments earlier in his evidence, when challenged on the issue of the 'final certificate', he did not raise the issue of roles as an explanation.

Where KRS requested work directly of Jonkar, the Superintendent (BSA) would retrospectively trigger the required paperwork to facilitate payment. Where the work is at the request of a project officer, the Superintendent signs a 'Superintendent's Site Instruction' in triplicate. Copies of that document are given to a number of parties, including the contractor. As work was often initiated by KRS direct, retrospective payment documentation was often issued. As this was the case it is argued that:

> *[i]n these circumstances BSA would not know about the work for some time, and therefore could not have been expected by the client to have reviewed the contractor's performance.*[134]

During the inquest Mr Stewart was questioned about a final certificate under his hand (on behalf of Mr John Mills) dated 16 May 1994 which stated: '*I certify that all works under the above contract have been satisfactorily executed*'.[135] He gave the following explanation:

> *Mr Grano: This relates to Jonkar Industries putting in an account is it for work done?*
>
> *Answer: No, I'd say that they've already done the work – – – Yes?– – –It's already been paid off. This might have been just for a holding deposit – whether there was even a holding deposit I don't know but we always issue a final certificate.*
>
> *Coroner: So you go and check to see if the work's been satisfactorily carried out, do you before you sign that certificate?*
>
> *Answer: Most times not.*
>
> *Coroner: So you wouldn't physically go out there to check to see the work has been done?*
>
> *Answer: No. It would have been done when the – when the contract was almost finished.*
>
> *Coroner: Well, how would you check – – – ? – – – Normally – – – to see it's done?*
>
> *Answer: Well, normally you go and do a site inspection.*
>
> *Coroner: Did you go and do a site inspection before you signed this?*
>
> *Answer: No.*
>
> *Coroner: Why not?*
>
> *Answer: Probably didn't have time.*[136]

Counsel assisting in further questioning of Mr Stewart on this issue put the following:

> *Mr Hicks: When someone says "I've certified something", that normally means something, doesn't it?*
>
> *Answer: Yes.*
>
> *Question: Someone's checked it?*
>
> *Answer: Well, probably does, yes.*
>
> *Question: But not in your department?*
>
> *Answer: No.*

134 Exhibit 299, pp. 4-5, para. 21.

135 Exhibit 227.

136 Transcript, p. 6669.

Question: Perhaps putting it the fairest way, it is a false document?

Answer: Probably is.

Question: It is a false document about a fire safety system, maintenance?

Answer: Well, yes.

Question: It's a false document about a system which is meant to be protecting people's life, the maintenance protecting peoples lives? (no audible reply) And you were happy to put your signature to it?

Answer: So that the deposit could be released, yes.

Question: No, to say that the works had been carried out, that's what the certificate says, does it not?

Answer: Well it does, yes.

Question: But whether they put in five thermals, two heat detectors, whatever, you don't check on it?

Answer: No, I don't.

Coroner: Is that the normal practice in your Department?

Answer: Yes.[137]

Mr Stewart also acknowledged that, 12 months prior to the fire, he would not have visited the site as Mills would have been looking after KRS. He conceded that it would have been obvious that BSA was not getting to the complex very often.

Mr Fox explained that the questioning on this issue related to the '*wrong final certificate*'. Evidently, due to an error a computer-generated certificate applying to a form of contract for major works was issued. Fox stated that '*[t]his certificate is far more detailed than necessary for an annual maintenance contract where the purpose of the final certificate is to release the contractor's security deposit or retention*'.[138] On the annual maintenance contract, the internal computer-generated final certificate is for the purpose of releasing the security deposit. Fox reasoned that '*[w]hile the certificate could be said to be false in that its contents are not accurate, it is irrelevant to the contract processes and most importantly was not relied upon by anyone except to release the deposit*'.[139]

In 1993, the Dibben Report commented on various service agreements with contractors such as Jonkar under the heading 'Equipment Maintenance':

> *There is no doubt these organisations are performing to an acceptable standard. However, this does not abdicate management from the responsibility of conducting periodic spot checks. Such action ensures the contract dollar is being well spent.*[140]

In addition, Dibben notes that '*[c]onsiderable cost savings can be achieved by staff conducting some regular maintenance checks*'. Such areas included: exit lights, thermal and smoke detectors, evacuation warning systems, etc.

Dibben recommended a process of spot checks, training of staff to '*conduct maintenance of ... thermal and smoke detector heads*' and to '*ensure that all work conducted under contract meets the relevant Australian Standard*'.[141] However, although Mr Dibben later (towards the end of the

137 Transcript, pp. 6674-6675.

138 Exhibit 299, p. 5, para. 23.

139 Exhibit 299, p. 5, para. 24.

140 Exhibit 54 – Dibben Report, p. 14, para. 1.8.4 (emphasis added).

141 Exhibit 54. See generally the Dibben Report, Recommendations 1-4, p. 15.

inquest) substantially qualifies his recommendation, the earlier comments still point strongly to the need for some degree of audit of the maintenance of the fire detection system. To underscore the issue, Dibben provided a priority for the work under the heading 'Implementation Strategy'. After commenting on DHS's duty of care, the report commented on the necessity for planning to have in [mind] '*the most vulnerable period for clients. This time is undisputedly outside normal daylight hours when on site staff is reduced'*. Further, the report stated that:

> *it is imperative, funds available for local maintenance programmes are spent to achieve and en result in context with the suggested plans. In the past large sums have been spent on a smoke detector programme. This type of initiative must fall within the standards and the overall plan.*

On the suggested priority, in order under item '1' (of nine items), one of three issues is to '*[d]evelop plans to oversee maintenance programmes and train local staff to conduct non-technical tests'*.[142]

Earlier, the 1992 Lumley Report recommended:

> *2.1.1 Review installation of fire detection systems to ensure efficiency of life and property protection and also, compliance with statutory requirements.*
>
> *2.1.2 Review specifications of service contract to ensure compliance with provisions of AS 1851.8.*
>
> *2.1.3 Centre officer to receive appropriate training to conduct weekly tests on randomly selected circuits of each system to record results of each weekly test and to also monitor tests conducted by contractor to ensure compliance with contract and that any discovered faults are immediately rectified.*[143]

In 1994 the ULA Report commented that '*[b]ased on the fire risk assessments, a fire in a residential unit could develop to a point where untenable conditions exist prior to full evacuation of the affected areas'* and '*[l]imited fire detection is provided. In many units there is a mix of heat and smoke detectors, with quite substantial number of areas having no detection at all. Where detectors are installed, many are old, discoloured and in need of replacement'*.[144] The summary of ULA's 'Fire Safety Audit' highlights (among a number of other points) '*[h]igher fire loads in the sleeping areas'* and '*[r]educing the numbers of staff lowers the probability of satisfactory staff response to an emergency'*.[145]

Following an analysis, the ULA Report commented on the value of sprinkler systems for life protection in residential areas at KRS. The comment was again made:

> *7.2 FIRE DETECTION SYSTEM – The present fire detection system has a number of problems: Mixture of heat and smoke detectors; Location of detectors not up to standard.'*

Further, it was stated that:

> *[t]o be an effective life safety feature, the fire detection system must be capable of early detection of a fire and initiation of an alarm both locally to warn the occupants, and centrally to indicate to staff and the Fire Brigade the location of the fire.*
>
> *Smoke detectors give the earliest warning, alerting staff to the presence of small incipient fires that can be extinguished or prevented from spreading, as well as maximising evacuation time.*[146]

142 Exhibit 54 – Dibben Report, p. 16.

143 Exhibit 53 – Lumley Report, p. 15.

144 Exhibit 143, pp. 1, 5.

145 Exhibit 143, pp. 6-7.

146 Exhibit 143, p. 18.

As previously noted, the '*Fabric Survey & Building Utilisation Study: Part A Kew Cottages'* stated:

> *During inspection it was noticed that many areas are not protected or have the wrong detectors installed eg. smoke detectors in laundries, thermal detectors in bedrooms, etc.*
>
> *The level of fire protection using smoke detectors is significantly higher than using thermal detectors, however, a trade off exists where detectors are used in inappropriate areas for false alarms and possible MFB charges. The fire protection system should protect the occupants before protecting the building.*
>
> *Many buildings did not comply with the Australian Standards and the BCA in terms of fire protection. A Maintenance Contract exists for the fire alarm system.*[147]

The Fabric Survey recommended fully protecting the buildings using '*smoke detectors throughout except where false alarms would result (Bathrooms, Stores Offices, etc)*'.[148] The Fabric Survey is a timely warning of potential problems in maintaining the system at KRS.

In light of the many comments by the Lumley and Dibben reports, the Fabric Survey and the ULA Report, the importance of a well-maintained fire detection system becomes far more obvious. Further, under the heading 'Additional Recommendations', the ULA Report recommended reconvening of '*the fire safety committee with clearly defined duties and responsibilities relating to the implementation and maintenance of fire safety systems and procedures'*.[149] The Fire Safety Committee was not re-established until after the fire on 8 April 1996.

In submissions on the issue of maintenance, Counsel for the Parents' Association argued:

> *The question arises as to what was the point in having a detailed written contact between Jonkar and BSA if no one intended to ensure that the terms of the contract were being complied with. In order to enforce the contract BSA may not have needed to physically perform "technical auditing" (ie. double checks, actual tests). They could however have required KRS to ensure such auditing occurred. The importance of auditing maintenance had previously been highlighted in the Dibben and Lumley reports. BSA could also have ensured that a file containing the requisite records which would help demonstrate that the contract was being complied with, was kept.*[150]

The MFB in its Submission argued that both Messrs Vasan and Taylor ought to have been alerted by the infrequent nature of Stewart's attendances to the fact that the system was not being monitored. In addition, the MFB pointed to it not being consistent with '*the fact that Mr Stewart was not provided with the false alarm reports in Mr Vasan's possession (T6132) which Mr Vasan himself did not regularly consider (T6130)*'.[151] The Submission further commented that DHS and BSA:

> *have stated a joint position to the inquest that the BSA's role did not extend to quality auditing (T6257). There is no evidence of any system being in place within either the Department of Human Services or the BSA whereby Mr Taylor and Mr Vasan were informed that the BSA was not carrying out performance monitoring. At all material times Mr Taylor and Mr Vasan acted upon the mistaken belief that the BSA was monitoring the performance of Jonkar Industries under the contract. The result of the arrangements that were in place (or, rather, the lack of them) was that the manifest inadequacies in the performance of Jonkar Industries went unnoticed until the inquest process began.*[152]

147 Exhibit 128 – Fabric Survey, p. 9.

148 Exhibit 128 – Fabric Survey, p. 14.

149 Exhibit 143, p. 20.

150 Parents' Association Submission p.40 para.113.

151 MFB Submission, p. 143, para. 242.

152 MFB Submission, p. 144, para. 244.

The MFB considered this *'entirely unsatisfactory state of affairs'* to be a systems failure. Although it was suggested that there was room for debate about monitoring by a *'principal of contract performance by a contractor, the situation revealed in the inquest whereby a life protecting fire safety system was not properly maintained over a number of years is not one that should have been allowed to continue'*.[153]

The Lumley, Dibben and ULA reports and the Fabric Survey not only emphasise the system deficiencies, but in varying degrees point to the importance of maintenance and audit of maintenance procedures. They illustrate some of the defects and risks within the then existing system and suggest reviews of the maintenance system. As far as review of the 'maintenance' system, the recommendations and comments of each of these reports were not followed. Each is clear and unambiguous.

A professional audit focussing on maintenance at KRS would have identified the many problems and failures to comply by the contractor. Confusion between roles of various government departments and agencies (KRS, BSA and DHS) helped to perpetuate a potential systems failure that had been well identified long before the fire. The consequences of the failure to provide an appropriate system of audit of the maintenance meant that any chance of identifying maintenance problems with the then existing fire detection and alarm system was lost.

The MFB also argued that documentation suggests that the responsibility for supervising the maintenance contract rested with the Public Works Department (and its successor, BSA). This is because the letter of 17 July 1992 appointing Jonkar states that work '*must be to the satisfaction of the Superintending Officer of this Ministry*'.[154]

It was submitted by Counsel for the Parents' Association that as the Minister for Finance Guidelines (November 1994, Guideline 3) provided that publicly owned buildings be maintained in a safe and serviceable condition, the responsibility for maintenance ultimately rests with the State of Victoria. Although not absolving the contractor this argument is persuasive. Indeed the guidelines were binding on the State under the Building Regulations 1994 SR 81/1994.[155]

3.6.4 CONCLUSION: MAINTENANCE

Other than the existence of a maintenance contract, there was little or no system to ensure that maintenance was properly undertaken at KRS. Mr Stewart's statement indicates that the contractor was to provide:

> *as soon as possible after completion of testing, and usually within one month after the testing is concluded, complete details of the testing undertaken. Those details include diagrams setting out the various buildings, location of detectors within the various buildings, details of relevant circuits, and the time responses for each detector. The information also included a brief report in relation to the various units, indicating any malfunctioning or deficiencies in any detectors.*

Unfortunately, there were a number of areas where there was little or no systematic method of checking on maintenance. Examples of the difficiencies in this area are as follows:

- Plans depicting the existence of new detectors were not supplied by the installer to Jonkar;
- Jonkar was not advised about renovations or given copies of the many fire safety reports;

153 MFB Submission, p. 145, para. 245.

154 MFB Submission, p. 143, para. 242.

155 In force from 1 July 1994: see Parents' Association Submission, p. 41, para. 115.

- No diagrams were provided by KRS indicating original wiring for the detectors ('as installed diagrams', which would have assisted in fault finding);
- No amended plans were provided to BSA (or Kew) by Jonkar;
- Any plans prepared by Jonkar (on Building 37) were inaccurate in a significant number of areas;
- There was no audit of plans (no dates on drawings, etc. Mr L. Neicho did not attend the site to check plans);
- Jonkar failed to follow the maintenance procedures in Australian Standards;
- There was no audit of maintenance;
- There was no contact between installer FFE (285 smoke detectors) and the maintenance contractor; and
- There was no regular contact between Wormald and the Jonkar maintenance contractor.

It would not be unreasonable to consider that the State of Victoria through one of its agencies – either DHS or BSA – ought to have been providing an audit of the maintenance of the fire alarm system at KRS. To say that it was not industry practice to include a provision for supervisory 'technical audit' in the contractual arrangements is to avoid the issue.

The systemic problem of the failure to technically audit maintenance was aptly described by the Villamanta Legal Service as a 'black hole'. At least one member of senior management in DHS (at CMB) was unaware of the fact that both DHS and BSA had agreed not to technically audit maintenance contractors' work. This is illustrated by the following exchange:

> *Question: ... Mr Lee says in terms of that statement to this inquest that the services provided by the BSA do not extend to quality contol of contractor's work, ie do not extend to scrutinising that work in terms of tradesman-like performance. Now I take it until you heard that yesterday that you did not know that?*
>
> *Answer (Mr Edgar): I did not know that.*[156]

It was a 'black hole' of knowledge on the part of KRS management and in at least one area of senior management at CMB. But it was also a 'black hole' of responsibility to ensure, as far as is practicable, that the fire safety hardware system was actually being properly maintained. That responsibility principally rests with DHS and the State of Victoria.

3.7 ABANDONMENT OF THE 'FIRE SAFETY COMMITTEE'

During the running of the inquest, on 31 October 1996, DHS acknowledged that there were a number of deficiencies in its procedures at KRS. Among the acknowledgments, it commented:

> *Fire evacuation drills and training were not comprehensive and did not cover all contingencies. Although the number of false alarms at the facility and the corresponding evacuations provided staff with a range of practice, it is acknowledged that they are not a substitute for structured and evaluated fire drills.*

156 Transcript, p. 6256.

In addition, while a site plan was made available to the MFB, there was no *'accessibility to any schematic floor plans of units'*. Many of these issues may have been identified had a Fire Safety Committee been in existence.

The history of the Fire Safety Committee is a chequered one. In 1992 Mr Taylor was requested by the Chief Executive Officer, KRS, to re-establish the Fire Safety Committee. Evidently, the Fire Safety Committee was considered an offshoot of the Occupational Health and Safety Committee.[157] Previously, during the 1970 and 1980s, KRS had a Fire Safety Officer.

On 11 June 1992, the first meeting of the committee was held. As already discussed, it ceased to exist in mid-1993. Fire Safety Committee membership included representatives from various divisions at KRS.[158] The Fire Safety Committee's composition and role were clearly defined in the KRS 'Fire Manual'. Its objectives and functions embraced a number of fire safety areas.[159]

In his statement, Mr Vasan detailed the type of issues covered by the Fire Safety Committee.[160] These included:

- review of the fire manual;
- organisation of fire evacuation drills (at the meeting of 15 September 1992, the fire evacuation drills are noted as being carried out in various units and notices sent to other units which have failed to carry out such drills);
- organisation of quarterly MFB fire equipment demonstrations and lectures;
- provision of fire keys to all units;

157 Transcript, p. 5343.

158 Both Messrs Taylor and Vasan were members. Other members were: S. Joseph, a nursing sector manager; T. Crawshaw from building maintenance; A. Murray from OH&S; G. New from Mr Taylor's staff; M. Pentiti who was a charge nurse; and G. Vessey who was the second in charge engineer. See generally Transcript, p. 5388.

159 Exhibit 4 – Coroner's Brief – Police Arson Squad, p. 282 et seq:

Composition of Committee:

Nursing

Facilities & Services

Engineering

Administration

Occupational Health & Safety

Responsibility for fire control in the establishment is vested in the Fire committee.

The Terms of Reference of the Fire Committee are: –

1. Develop policies and procedures for fire prevention, fire fighting and evacuation within the establishment.

2. Arrange the conduct of training courses for staff in fire prevention, fire fighting and evacuation.

3. Ensure that all staff are acquainted with the contents of the Fire Manual.

4. Monitor and where necessary, ensure that proper fire prevention housekeeping is implemented throughout the establishment.

5. Ensure that all fire fighting equipment is maintained in accordance with Australian Standards.

6. Investigate and analyse reports on all fire accidents. with a view to prevent re-occurrences.

7. Develop a close liaison with professional fire fighting organisations in order to incorporate the latest techniques and equipment into the establishment's fire control system.

8. Furnish proposals for annual capital expenditure and annual provisions projects to the (sic)

9. Establish work priorities for expenditure of fire fighting funds.

10. Ensure compliance with the Victorian Building Regulations.

160 Exhibit 176 'SV3' – Mr Vasan's statement.

- nomination of fire wardens for each building (including providing each unit with a fire warden's uniform);
- fire safety wall charts for all buildings (including the updating of charts following building renovations);
- determining the role of the engineer in the event of fire;
- determining the role of the switchboard in the event of alarm in the administration building;
- finding a fire beacon and smoke simulator for use during fire drills;
- being advised of progress on outstanding works on major issues and annual provisions programs (this included the upgrading of fire mains and the installation of smoke detectors and upgrading of fire alarm system);
- at the meeting of 18 August 1992 the wiring of Unit 3 with mains-operated smoke detectors was discussed. It was noted that KRS was 'introducing the same system to other units included in the works and services program 92/93'.
- discussion of the memorandum of 18 June 1992 on smoke detectors;[161] and
- discussion of installation of sprinklers.[162]

Mr Vessey, KRS assistant engineer, reported to the Fire Safety Committee on the progress of implementation of the Lumley Report on hardware issues such as hose reels and pictorial signs, extinguishers and fire blankets.

Jonkar's Mr L. Neicho stated that he had a discussion with the Fire Safety Committee about extra bells and warnings in buildings.[163] The Villamanta Legal Service Submission makes a telling point when it remarks '*[s]o the Committee stretched its purview to the maintenance contractor and ways the contractor could assist in improving safety'*.[164] It is again noted that the ULA Report recommended the reconvening of the Fire Safety Committee with '*clearly defined duties and responsibilities relating to the implementation and maintenance of fire safety systems and procedures'*.

The Fire Safety Committee was disbanded because it had finished its job, and it was considered that the issues had been satisfactorily addressed. Mr Taylor viewed issues, such as the monitoring of fire or evacuation drills, training and review of systems, as being passed on to line management – Direct Care services.[165] Non-Direct Care services retained areas such as organising the training and fire evacuations. In comparison Mr Vasan considered that '*the fire manual and arranging fire evacuations, drills, making sure the fire warden material was available in the units'* was handed over by Mr Taylor *'to the direct care; that is nursing section'*.[166] Vasan was not sure who in direct care took over the role. Apparently, the Direct Care staff representative on the committee had taken a redundancy package.[167]

Mr Taylor envisaged that the Fire Committee:

161 Exhibit 240.

162 Transcript, pp. 5343-5344 (evidence of Mr Taylor).

163 Transcript, p. 4226.

164 Villamanta Legal Service Submission, p. 13, para. 6.2.

165 Transcript, pp. 5388-5389 (evidence of Mr Taylor).

166 Transcript, p. 5933 (evidence of Mr Vasan).

167 Transcript, p. 5933 (evidence of Mr Vasan).

would probably get regenerated at the completion of the upgrade, when...a whole new system (was) in place, and the focus would then be on the updated version of the fire protection system.[168]

Apparently, after the disbanding of the committee, Mr Vasan took responsibility for 'extinguishers'.[169]

The Villamanta Legal Service also submitted that:

the Fire Safety Committee was the last management structure prior to the fire which:

- *had an overall perspective on the fire safety situation at Kew; and*
- *sought to implement appropriate fire safety activities and hold accountable those sections of Kew which failed to undertake these activities; and*
- *had communal knowledge that would not be lost if one party changed position.*[170]

Further, the Legal Service made the point that '*the demise of the Fire Safety Committee resulted in a fragmentation of approach to fire safety issues at Kew'*. After the demise of the Fire Safety Committee, its responsibilities appeared to devolve in the following way:

(1) Facilities Management – fire extinguishers, fire blankets, signs and maintenance.

(2) Direct Care Management – fire evacuation drills, MFB training and lectures, fire evacuation plans, fire wardens and the administration switchboard.

The demise of the Fire Safety Committee meant that the Direct Care area lost a valuable information source and risk management tool. The Facilities division also had little idea of the effectiveness of training and development of evacuation plans following renovations. The systemic problems are well summarised in the Submission of the Villamanta Legal Service:

VLS submits that an overall appreciation of the state of fire safety system, the need for an upgrade and the dangers for staff and residents is lost particularly to the direct care side of the organisation. The Facilities side of management lose contact with the incidence and frequency of staff training, the development of new evacuation plans when renovations have occurred, the provision of wardens' garb and fire keys.

The evidence of Mr Taylor, Mr Radler and Ms. McCartin in respect of their appreciation of risk provides an example of this fragmentation. Mr Taylor had a profound appreciation of the inadequacies of the fire safety system hardware. Mr Radler, Acting Manager of Direct Care Services from February 1995 to August 1995, was not aware that due to the small spread of smoke detectors throughout the residential units, the system could not give as early a warning as it would have if it had a coverage of smoke detectors (6485). He was aware that there were no sprinklers and that some units lacked local alarms. (6484-5).[171]

Ms. McCartin, who was in her position only six months before the fire, noted that '*my sense was that the upgrade was in hand and the various exercises to get to commencing the upgrade had been undertaken. So I in fact devoted myself to other tasks that didn't have that level of intervention'*.[172] Ms. McCartin's predecessor, Mr Radler, was not aware of the detail of the ULA

168 Transcript, p. 5389 (evidence of Mr Taylor).

169 Transcript, p. 5971 et seq. (evidence of Mr Vasan).

170 Villamanta Legal Service Submission, p. 13, para. 6.2.

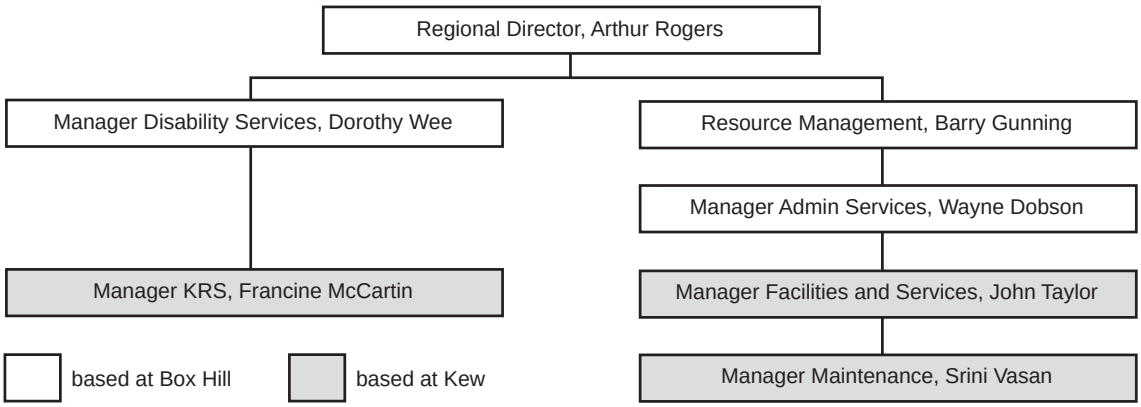
171 Villamanta Legal Service Submission p. 14, para. 6.2.

172 Transcript, p. 6775.

Report. However, he did have some knowledge of the problems with fire drills and evacuation. As a witness in the Tran inquest, he had some knowledge of fire safety issues. Mr Radler said:

> *I was quite vocal about fire risk and the current system at Kew which I felt had deficiencies. I was quite vocal to the point where people thought I was obsessive about fire management issues that I expected, assumed that I would have been informed of anybody with fire risk behaviours. ...*
>
> *Coroner: So in spite of your interest in and commitment to the area, and experience in the area, ... you weren't being taken notice of?*
>
> *Answer: All I can say is that my impression was that there were no clients at Kew with fire risk behaviours.*[173]

The Villamanta Legal Service provided a compelling argument that the '*split in management responsibility for fire safety reflects the overall split in management at Kew. By the time of the fire there was no one person at Kew to whom everyone at Kew was responsible'*.[174] It provides a useful diagrammatic summary of the management structure at KRS[175] at the time of the fire:



In conclusion the Legal Service submitted that the:

> *fragmentation of management responsibility for fire safety had significant consequences. The first is that issues of staff training, the engagement of MFB services and the development of evacuation plans using staff from surrounding units was left to unit managers (Evidence of Barry Wales (1801)). At the time of the fire many staff had not undergone sufficient training, many of the 'buddies' were unfamiliar with the layout of Unit 31, Mr Frlan was unaware of the evacuation route requiring Door 1 to be open during the night, the fire warden was not wearing his garb and MFB officers were not all clear who was in charge, keys could not open all doors, client lists were not readily available.*[176]

173 Transcript, pp. 6507, 6508.

174 Villamanta Legal Service Submission, p. 15, para. 6.2.

175 Villamanta Legal Service Submission, p. 15, para. 6.2 (taken from Exhibit 187).

176 Villamanta Legal Service Submission, p. 15, para. 6.2. See also the comments of the Parents' Association, p. 54, para. 147: *'Whether because of the absence of a fire committee or not, two further major defects can be identified in the management structure at KRS prior to the fire. ...*

(a) the failure to nominate a fire warden as the identified manager of emergency response;

(b) the failure to co-ordinate management of fire related issues:

(i) between management and staff; and

(ii) between the facilities stream and the direct care stream of staff'.

The Parents' Association observed that the wide '*representation by personnel on such a committee may well have created a greater awareness among direct care staff of the catastrophic potential of a fire at KRS. The local MFB branch was well aware of this potential'*.[177] In one of its most telling comments, it put that:

> *good management policies ought to recognise the interrelationship of risk management issues and occupational health and safety systems. When a system fails as in a workplace accident it is rarely as a consequence of a single isolated factor but rather more commonly a domino like pattern of interlinked faults and deficiencies which involve all streams of personnel and management.*[178]

The pattern of '*interlinked failure is the outstanding feature of the fire tragedy'*. An examination of the role and demise of the Fire Safety Committee is but one example of a series of interlinked failures. Further, it was regrettable that:

> *the direct care management stream at KRS operated totally independently from the facilities stream prior to the fire because this splitting of responsibility resulted in an unco-ordinated and ineffectual response to reports and issues which affected both streams. The Lumley and ULA Reports seem to have barely filtered through to direct care management, although each contained vital recommendations within the ambit of direct care staff.*[179]

The existing Fire Manual (as at 8 April) had foreseen the difficulties and provided for membership from a number of areas and disciplines at KRS. In an even more pointed remark, the Submission of the Parents' Association continued:

> *There has been a consistent pattern of inattention and neglect in the prioritising of fire risk at KRS over a number of years and this pattern has its origins with the inaction of management and Mr Taylor and Mr Vasan. Appropriate emphasis on all aspects of fire risk and fire response systems by these individuals should have been echoed both directly and indirectly throughout the direct care staff at KRS in their day to day dealings with clients. This neglect was furthered by the failure to regularly review the total fire detection system and supervise Jonkar's maintenance practices.*[180]

The Dibben Report had commented on the importance of the Fire Safety Committee, so too had the ULA Report. ULA's recommendations about the committee were ignored. Had it been reconvened as suggested, some of the issues about maintenance may well have been identified. Difficulties with training and evacuation may have been identified and resolved. Had the Direct Care area possessed more detail on the renovations to Unit 31 and the resultant fire risks, a different approach to management of the unit may have occurred.

3. 8 FIRE DRILLS AND EVACUATION PROCEDURES

3.8.1 HISTORY AND SYSTEM

The need for well-developed staff fire drills and evacuation procedures are obvious. An examination of the 1968 Willsmere fire highlights the need for regular and evaluated training. The safety of

177 Parents' Association Submission, p. 52, para. 143.

178 Parents' Association Submission, p. 52, paras. 141-142.

179 Parents' Association Submission, p. 56, para. 156.

180 Parents' Association Submission, p. 56, para. 158.

staff, residents and the public may well depend on how efficiently a particular incident is managed. Recommendations on improvements in management, training, practices and procedures can be seen throughout the Lumley, Dibben and ULA reports. The existence of a well-managed and directed Fire Safety (or Occupational Health & Safety) Committee is vital to ensure that staff are trained for fire emergency. KRS did not have a Fire Safety Committee at the time of the fire. The Public Advocate stated that:

> *[t]he way in which staff respond to emergencies such as fires is vital to the prospects of survival for residents with intellectual disabilities. The intervention of staff can be life-saving or it can be obstructive to attempts to save lives. The procedures employed to attempt to save residents by evacuating them can be described as the single most important intervention for saving life. Given the failure of the fire detection system on 8 April 1996, and the absence of full sprinklering and a sound early warning system, Kew Residential Services staff and the Melbourne Fire Brigade provided the only potential link for residents between the environment in which the fire occurred and safety.*[181]

At KRS, the planned training was infrequent, and staff appeared to rely on false alarms to provide additional support in this area. There was little systematic planning to *'reach all areas of staff, to educate staff in appropriate procedures and to reinforce that education by repeated, qualitatively evaluated experience'*.[182] DHS acknowledged that *'[f]ire evacuation drills and training were not comprehensive and did not cover all contingencies. Although the number of false alarms at the facility and the corresponding evacuations provided staff with a range of practice, it is acknowledged that they were not a substitute for structured and evaluated fire drills'*.[183]

There were evacuation protocols in place but they were not regularly evaluated.

3.8.2 DEFICIENCIES

By the time of the fire, deficiencies in fire drills and evacuation had been well identified. In 1992, the Lumley Report commented that '*although drills have been conducted, advice received indicated that drills tended to be on an ad-hoc basis by various units*' and recommended:

> *3.2.1 Evacuation drills to be conducted on a planned regular basis so that effectiveness can be monitored and where applicable, procedures improved or updated;*
>
> *3.2.2 At least one evacuation drill per year for each unit should be conducted at night;*
>
> *3.2.3 Evacuation drill requirements to be considered during the establishment of night shift rosters.*[184]

Later, deficiencies identified by the Dibben Report were:

- disorganised staff;
- poor co-ordination;
- difficulty in opening doors (some keys unavailable);
- poor procedures; and
- some resident resistance.

181 Public Advocate's Submission, p. 69.

182 Public Advocate's Submission, p. 70.

183 Transcript, p. 1104.

184 Exhibit 53 – Lumley Report, p. 25.

The Dibben Report also recommended a holistic approach to fire prevention and that *'all staff should receive training in the use of extinguishers, fire blankets and hose reels. It is necessary to provide regular training – say six monthly for all night and day staff'* and the training *'should be conducted in conjunction with emergency procedure training'*.[185]

Finally, the ULA Report suggested that KRS should:

> *[e]nsure all staff receive regular (at least annual) training in emergency procedures and the use of first response equipment;* [and]
>
> *Continue to implement and record regular emergency response drills including trial evacuations both during the day and night.*[186]

Some of the deficiencies identified by the MFB during the night of the fire include such areas as: the evacuation marshalling point; in obtaining a list of names; no identified fire warden; and the effect of the complexity of the building on the evacuation.[187]

The Parents' Association pointed to a number of staff who did not appear to have fire risk appreciation or appropriate preparation for fire emergency. They included McCoach, Pragnaratne, Noter, Vine, Tosevski, Andreopolous, Stanisaljevic, Schwab, Wales, Ansorge, Sen, Sibia, Sango, O'Hare, Phillips, Frlan, Free and Carracher. Neither '*Mr Frlan nor Mr Chea had ever undertaken a night time fire drill in 30/31 and many of the night time buddy staff were inexperienced in fire drills generally and were completely unaware of the layout of the burning building which they were expected to evacuate'*.[188] The Parents' Association also pointed to Mr Radler's evidence which suggests that

185 Exhibit 54 – Dibben Report, pp. 6-14.

186 Exhibit 143 – ULA Report, p. 20.

187 MFB Submission, pp. 39-42, paras. 92-95, 97. Note: quotations summarised:

The evacuation marshalling point

The planned evacuation marshalling point for the units was near the rotunda to the north of Flat E. This location was not protected from the fire on the northern side of the building. This was realised by KRS staff and no clients were evacuated to that point. This resulted in there being no definite point of evacuation until the scene was brought under control by the MFB and KRS staff at a subsequent stage.

Difficulty in obtaining a list of names

There was difficulty experienced by the MFB in identifying the number and names of the clients who were resident in Unit 30/31 generally and Flat E specifically. It was not until a relatively late stage in the conduct of the evacuation that it was possible to identify with certainty the names of the persons missing and presumed deceased.

No fire warden

As later analysis in the submission shows, when the MFB arrived there were about five persons engaged in evacuating 36 living disabled clients from Unit 30/31 (nine had died by this time) – two from the unit and three from the administration area and other units. These persons were severely taxed by the circumstances confronting them.

It appeared to the MFB that there was no person in effective control of the evacuation or the fire scene during the early stages. No person specifically identified themselves at the scene as being responsible for giving information or directing the MFB to the seat of the fire itself.

There was a jacket for the identification of the fire warden in the office but this was not used (T1192).

The speed of events must also be acknowledged. Nevertheless it appeared that it took some time for KRS management staff to move from their evacuation to their management role.

The effect of the complexity of the building on evacuation

Unit 30/31 is a complex structure with many rooms and interlinking corridors. Most of the MFB personnel were not familiar with the building, and neither were many of the KRS staff from other units. No floor plan was produced to the MFB when this was needed at the early stages of the fire fighting and evacuation effort, although Mr Vasan produced one a little later (T5716).

188 Parents' Association Submission, p. 58, paras. 165, 167.

'*inadequate fire drills were a long standing problem'*. The Submission commented on Annexure '0' to Radler's statement which records that '*[a]t yesterday's Unit Managers Forum some Unit Managers reported that many unit staff have not received training in fire procedures for up to five years'*.[189]

Shortly before the fire, there was little attention to improving the delivery in the area of drills and evacuation, as is evidenced in the comment by Ms. McCartin:

> *[M]y sense was that the upgrade was in hand and the various exercises to get to commencing the upgrade had been undertaken. So I in fact devoted myself to other tasks that didn't have that level of intervention.*[190]

The State of Victoria through its agent DHS did not ensure that adequate training in fire drills and evacuation procedures took place at KRS in spite of a number of reports and recommendations, combined with a '*lack of faith*' in the fire safety system.

3.9 MANAGEMENT OF FIRE-LIGHTING RISK BY DHS

3.9.1 PAUL AND THE MANAGEMENT OF 'FIRE-LIGHTING BEHAVIOUR' OR 'RISK'

Paul was aged 38 at the time of the incident. He resided in Building 37, Unit 31, Flat E, and shared his bedroom with Messrs Grant and Newman (both deceased). Paul was intellectually disabled and suffered from epilepsy, and had resided at KRS since October 1963. His Departmental file records (listed in apparent date order):

- *IDS Client Information System – Client Profile General Alerts: Sets Fires ... (dated 21-12-90)*[191]
- *IDS Client Information System – Client Profile General Alerts: Sets Fires ... (dated 02-01-91)*[192]
- *Nursing Notes – General Nursing Review 1991 – Has a history of setting fire when he has the opportunity of possessing a fire lighter. Dated 3-9-91.*[193]
- *General Service Plan – Current Situation – Arson (if opportunity) ... Document dated 27-9-94.*[194]
- [Paul] – *Challenging Behaviour Inventory – Arson – Will try to set alight and burn flammable items, if he can obtain matches or a lighter* [and] *under the heading Current Situation 'Arson (if opportunity)* ... [appears to be the facing sheet for a 'General Service Plan' Document dated 19-10-95][195]

189 Parents' Association Submission, p. 58, para. 168.

190 Transcript, p. 6775.

191 Exhibit 4 – Coroner's Brief – Police Arson Squad, p. 81.

192 Exhibit 4 – Coroner's Brief – Police Arson Squad, p. 80.

193 Exhibit 4 – Coroner's Brief – Police Arson Squad, pp. 5-7, especially p. 7.

194 Exhibit 4 – Coroner's Brief – Police Arson Squad, p. 10.

195 Exhibit 4 – Coroner's Brief – Police Arson Squad, pp. 24-25.

There is no detail of any incidents on which the above assessments are made. A search of Paul's file before 1990 does not disclose any other reference to fire-lighting behaviour or incidents. The file does detail a number of other challenging behaviours, including absconding, keeping sharp objects, tendency to be aggressive and destructive. There are also comments on smoking, such as: *'likes to smoke cigarettes and will ask people, when he is out of the unit, for cigarettes. Is not able to make an informed decision regarding smoking'*.[196] The 'goal' of the management direction on this issue was to '*maintain nil to minimal smoking'*, and the '*strategy'* was noted as '*Paul not to be given cigarettes by unit or other staff when in the unit and immediate area of the unit. Staff awareness'*.[197]

Apparently, there are a number of documents missing from the file. Those missing documents are:

- General Service Plans – 1989/90; 1992/93; 1993/94
- Individual Program Plans – 1989/90; 1990/91; 1991/92; 1993/94

In her statement, Ms. Lesley Vincent, a Unit Manager, indicated that:

> *[o]n the 27th September 1994 a review of the General Service Plan of Paul a client in Unit 31 was conducted. Present at the meeting were Sam Tsaousidis and myself with Paul intermittently. Discussions had occurred prior to the meeting with Simon Cawley but he was not in attendance at the meeting.*
>
> *The reason for the meeting is that it is a requirement under the legislation and the purpose is to identify a person's service requirements and needs in all major life areas. At the particular time when this report was done, I think it was still mandatory to address eleven life areas. Behaviour is generally addressed at Kew under the heading of 'Health' but I also address behaviour under the heading 'Living' as it largely identifies the support levels required by clients, and it will assist in determining their future living situations ...*
>
> *(In the General Service Plan) ... I have written the words: Challenging Behaviour, Arson (if opportunity) ... (and under the heading 'Challenging Behaviour Inventory') ... I have typed 'Will try to set alight and burn flammable items if he can obtain matches or a lighter.'*
>
> *When I first started in Kew in 1975 I worked in the old hospital unit as a Ward Assistant. Not long after that I remember a fire in a painter's van. At that time it was very well known that Paul had set the van on fire.*
>
> *In March 1993 when I first went to work in Unit 31 ... I then went about making my own enquiries with the old staff and history searches through the files to learn about the clients. When I was going through Paul's file there was definitely an Incident Report relating to a fire with the van back in 1975.*
>
> *In 1994 I completed a review of a General Service Plan on Paul. As far as I can recall this was the first review of a General Service Plan I completed on Paul. I basically included all the information I had discovered on Paul, including the Arson, this information was not in a condensed format anywhere else.*
>
> *The arson was included as it is potentially dangerous behaviour and it has to be acknowledged to be addressed. Also the General Service Plan and Individual Program Plan are our only working documents and every staff member is supposed to have access to them, and it is the only document every staff member does have access to that contains*

196 Exhibit 4 – Coroner's Brief – Police Arson Squad, pp. 18-19.

197 Exhibit 4 – Coroner's Brief – Police Arson Squad, p. 18.

condensed information on clients. The secondary reason was that staff be made aware so they could be conscious of this when they were supervising them. ...

[O]n a couple of occasions Paul would return from programs, and because of his habit of picking pockets and collecting sharp items, which he used to cut his fingers with, myself or other staff members would check his pockets on his return. On occasions, I think twice, I found matches in his pockets.

I have seen him light matches for cigarettes and I have once seen him light a cigarette and light a piece of paper. When the paper started to burn he was surprised, he got a shock and put it out. ...

Based on what I know of Paul, my experience with how he reacts when he is involved in something he shouldn't be doing and based on how I found him Tuesday morning I don't believe he was involved in starting the fire.[198]

Ms.Vincent worked in Unit 31 between March 1993 and October/November 1994. In evidence, she stated:

Now I had to make an assessment in regard to the rumour as to whether there was any likelihood or what were the chances of that rumour being true and given Kew Cottages 1975, I believe, that the chances of that rumour being true were fairly high. I also had to make an assessment on whether I thought or what the chances were of that particular type of incident occurring and not being documented properly, and in 1975 at Kew Cottages that was highly likely to have been possible or probable.[199]

Documented assessments of Paul indicate that he is *'very bright and cheeky. Likes picking things up and putting them in his pockets. Has no speech, but understands everything. Can be aggressive and destructive when upset'*. Nursing notes (dated 3/9/1991) indicate that he has some skills and understanding:

Paul is confident enough to carry out his self-help skill in a decisive way. He is capable to dress and undress himself and even doing up buttons also doing up shoe laces ... He makes his own bed, also helps out with simple domestic tasks in the unit, eg: folds clothes, puts away linen and sheets, towels, puts face washers into washing machine. He enjoys and also voluntary looking for tasks to occupy his time. He can perform the shaving task with an electric razor and needs assistance as well as close supervision. He has the tendency to shave off his eyebrows and his hair. He participates in unit training programmes in order to achieve his skill in self serving a meal ... He uses knife and fork appropriately and has the understanding of the knife usage such as peeling fruit and cutting fruit into small pieces ... [there are further examples in the nursing notes ab out his level of skill].[200]

Ms. Vincent, during her time as Unit Manager of Unit 31), compiled GSPs and IPPs for Paul. In her 'End of Financial Year Report' (June 1993), Vincent commented that '*[m]any GSP and IPP reviews have been rescheduled as staff are too unfamiliar with clients to be able to address the needs of the client adequately and no systems exist to support the process during Assessment, Review, Implementation, Monitoring and Evaluation'*.[201] However, in the report, it was acknowledged that since March 1993, emphasis had been placed on '*[g]aining an insight and knowledge of the*

198 Exhibit 4 – Coroner's Brief – Police Arson Squad, pp. 225-226.

199 Transcript, p. 6316.

200 Exhibit 4 – Coroner's Brief – Police Arson Squad, pp. 5-6.

201 Exhibit 260, para. 4.1.

clients and their individual needs' and '*[f]ollowing up of client challenging behaviour issues'*.[202] It is apparent that Ms. Vincent assumed that this record on the file, along with searching of Paul, was sufficient to manage any potential problem.

The police documentation for the 1975 fire incident involving a tradesperson's van (obtained during the inquest) does not identify an offender. An examination of the statements of a number of witnesses show that, while some were aware of the rumour, many were not. Some staff working at KRS during the late 1970s were not aware of the incident. Ms. Vincent explained that she saw a report on the incident implicating Paul but had been unable to locate the document. The State of Victoria submitted that it is highly doubtful that such an incident report exists. Against this the inquest has observed other instances of missing documents or files; for example, the BSA file on the checking of Jonkar's references could not be located and there was no record of the 8 May facsimile from Paino to Vasan in KRS's file.

Ms. Vincent observed Paul burn a newspaper in 1993.This incident is referred to in her statement and during evidence. However, she did not record the event as an incident. The State of Victoria submitted that '*it is inconceivable that she would not have mentioned this to a person conducting a Survey for the express purpose of assessing fire safety in the units. It is highly probable that Ms Vincent was on duty and that she did speak to Mr Lai and expressed no such views because Paul was not considered by her at that time to be a firelighting risk*'.[203] Mr Lai, who was performing his audit about this time, thought that if a Unit/Deputy Unit Manager considered that an arsonist was in residence he would be informed.[204]

The State of Victoria further argued:

> *Indeed, Ms Vincent was firmly of the view, at the time, that the informal management strategy in place, of searching Paul on a consistent or regular basis, had been and would continue to be effective (T.6434). Nor does Ms Vincent state that she would have included any additional process on a day-to-day basis in terms of monitoring Paul (T.6437). This raises further doubt concerning Ms Vincent's observations of the 1993 newspaper incident.*[205]

Investigation has disclosed another unrecorded incident. One example of behaviour potentially linking Paul as a risk factor can been seen in a statement by Mr Pragnaratne, who said:

> *I have seen Paul handling the cigarette lighters of staff members and I have once seen him try to light a staff member's cigarette lighter. On this occasion he held the lighter in one hand and tried to light it with the thumb or index finger of the other hand. I remember it because he burnt his finger by purposely putting a finger on the flame after lighting it. He did this before I could take it off him.*[206]

This occurred sometime in 1995, but it was not recorded. Professor Robert Adler, Royal Children's Hospital, considered that it should have been.

In its Submission, Villamanta Legal Service commented about the file notes on Paul's behaviour that '*much of this evidence is hearsay, some of it is hearsay of hearsay (the rumour for instance). On the other hand there is sufficient association of Paul with fire to cause a response which would*

202 Exhibit 260, paras. 2.4 1, 10.

203 State of Victoria's Submission, p. 159, para. 3.43.

204 Transcript, p. 3576.

205 State of Victoria's Submission, p. 159, para. 3.45.

206 Exhibit 78.

require observation'.[207] The State's Submission considered that the note on the 1975 incident is somewhat less than 'hearsay'; it is mere rumour.

Apparently, there was no strategy aimed at managing Paul's 'fire-lighting risk'. Nor is there any indication of a directed investigation of his recorded and alleged 'fire-lighting behaviour'.

Mr Rod Carracher, Acting Unit Manager of Unit 30/31, took over that role in late November 1995 and held that position until late March 1996. Carracher had not read Paul's file. He indicated that, had the file been read and the warnings observed, he would have expected '*such behaviour would have been dealt with in the IPP in the form of a strategy developed to deal with fire lighting behaviour ...* [and] *... the behaviour referred to BIST ... either BIST or a client service psychologist would be contacted to develop a strategy'*.[208] Carracher would have expected the details to be on the 1994 IPP. He stated that:

> *[i]f these matters were in place I would have learned upon my commencement as Acting Unit Manager of the fact that Paul was being monitored as a "fire-lighter" and that there was a problem. As no such action had been undertaken nothing was conveyed to me.*[209]

There were a number of outstanding 'GSPs/IPPs' (about 16 'GSPs' and nine 'IPPs') for the residents when Carracher took over management of the units.

A former Unit Manager of Units 30/31, Mr Edward Eyre, was of the view that Paul was not perceived as having highly challenging behaviour. On taking over after the amalgamation in November 1994, Eyre:

> *conducted two planning days for staff to discuss how the altered unit would operate. We discussed each individual client at those planning days and we looked over their GSPs and IPPs to ascertain all the relevant information about them. In particular we familiarised ourselves with the files of clients who were perceived as having highly challenging behaviours. Paul was not considered to be such a client. He was more accurately described as helpful, compliant and relatively intelligent. In the context of the 52 clients we were dealing with, some of whom had ultra-challenging behaviours, Paul did not seem to be a problem. As Manager of Unit 30/31 I had no information relayed to me either orally or in written form to indicate that Paul had any tendency to light fires.*[210]

Mr Eyre reported that he and his senior deputies read most of the files for residents in Unit 31 and drafted alerts. He did not recall any alert or other significant challenging behaviours on Paul's file. After the fire, Eyre perused the file and said:

> *[r]ecently I perused Paul's 1994 GSP which states in the challenging behaviour inventory that he will commit arson if given the opportunity. I have never seen that before. My response as Unit Manager to challenging behaviour by clients varied according to the severity of their behaviour. If I had seen the entry about arson I would have included such an entry in an alert, held a case meeting on the subject for both shifts, implemented strategies via the IPP and put a warning on the alert board. I consider such behaviour to be very serious.*[211]

At this stage it is clear that there was sufficient detail in the file, as prepared under Vincent's direction, to alert a manager. Unfortunately, this detail was not observed. This would have provided a further opportunity to reconsider Paul's management.

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207 Villamanta Legal Service Submission, p. 51.

208 Exhibit 129, para. 10.

209 Exhibit 129, para. 10.

210 Exhibit 258 – Mr Eyre's statement, para. 9.

211 Exhibit 258 – Mr Eyre's statement, para. 12

Ms. Margaret Smith, an Intellectual Disability Services Officer, stated that she had worked in Unit 31 for six years up until 1994 and had known Paul. She had *'seen him handle cigarette lighters and matches that he had picked up from staff members but have never observed him light anything or smoke'*, and stated that:

> *Paul has a habit of collecting items and we always checked his pockets for things he might have picked up if he had been out for the day. I am familiar with the rumour that Paul set fire to a car many years ago. Paul's disability, like so many of the residents, prevents him from realising the effects of fire and he has to be watched like you would watch any small child who did not understand such dangers.*[212]

Ms. Smith acknowledged she would have had to read the file to find out about Paul's background but had no memory about the references to arson. She said that:

> *I do not remember anything to justify Paul being labelled an arsonist, I just knew you had to be careful when he collected objects that he did not have dangerous ones in his possession. Leslie Vincent did not tell me about the entries relating to firelighting in Paul's GSP, similarly I was not told that there were any strategies to deal with such behaviour or that he was a firelighter.*[213]

A number of carers made statements to the effect that they had read the file but were not aware of the warnings on fire-lighting nor did they see any behaviour to raise their concerns about the issue. Those carers include Messrs Simon Crawley, Baljit Jessy, Paramjit Singh and Henry Lim and Ms. Glenda McInnes. Some carers who had not read the file and were not aware of any fire-lighting behaviour (playing with cigarette lighters or matches) include Messrs Petros Kotopodis, Youssef Barakia, Krist Boglis, Milan Krimpotic, Anthony LeFleur, Melville Ranasinghe and Michael Rupa and Ms. Liana Coppellato. Mr Barakia was aware of the rumour that Paul had set fire to a television repairman's van and had seen him smoking on a small number of occasions. Many of the carers were not aware of the 1975 rumour. Mr Kotopodis said in his statement:

> *I would not have read Paul's file as I knew him so there was no need to. I don't remember seeing Paul's client profile and was not aware that there was any general alert that Paul sets fires. I don't believe that I have ever read Paul's GSP or IPP and as far as I am aware he did not have any problem regarding firelighting behaviour. He was not perceived as a risk in this regard. He liked to collect items, but I never saw him collect a cigarette lighter or matches. Leslie Vincent never informed me about any entries on his GSP relating to Paul having arsonist tendencies or that there were any strategies in place to deal with such behaviour. She never indicated to me that Paul was a firelighter or an arsonist and I never considered him to be such a person.*[214]

Ms. Monica White, Acting Deputy Unit Manager, stated:

> *9. Until recently I was not aware that Paul's file contained a client profile with a general alert that he "sets fires", or that the 1994 GSP cited as a challenging behaviour arsonist tendencies by Paul. Indeed I am surprised by the entries particularly as I had no reason to suspect any justification of such entries. I am surprised that if Paul did exhibit such tendencies I was not informed of them.*
>
> *10. I have only seen Paul try to light a cigarette lighter once. This was in about January 1996 on the decking between Flats C, D & E in the presence of staff. He picked up a lighter belonging to a staff member and tried to light it but couldn't. I took the cigarette*

212 Exhibit 258.

213 Exhibit 258.

214 Exhibit 258.

lighter off Paul and told the staff member to put it away. I did not consider the incident worth reporting because Paul was a client who consistently picked up objects and that was a problem that had previously been identified.[215]

Mr Hedy Medalle was involved in the preparation of Paul's IPP under the direction of Ms. Vincent. Medalle stated:

At no time during the preparation of the IPP was it mentioned to me by Lesley Vincent that Paul had fire-lighting tendencies or that the IPP should state as an objective any reference to his fire-lighting tendencies. If I had received the challenging behaviour inventory I would have noted the reference to arson unless it was agreed after discussion that it was not a current problem that needed to be addressed, I must have noted the reference to arson in the GSP but we did not include anything in the IPP specifically relating to this issue. I do not remember what we discussed about this at the time but there must have been some discussion that led to the conclusion that we should disregard arson as a challenging behaviour which should be dealt with in the IPP ... At no time was I informed that the IPP should include a strategy to deal with any fire-lighting behaviour, or that there was any such strategy in place to deal with it or that there should be. As far as I was concerned, Paul did not exhibit any challenging behaviour in this regard warranting mention as a challenging behaviour or development of strategies.[216]

However, Mr Virkumar Gungaphul, Deputy Unit Manager (Unit 30/31) from January 1996, who oversaw the preparation of Paul's GSPs and IPPs, stated:

6. I never had cause to read Paul's GSP and IPP for the previous year. I have now read the same and noted that in the GSP there is a reference to arson and in the challenging behaviour inventory, a reference to, under the heading "arson" – Paul trying to set alight and burn flammable items if he could obtain matches or a lighter. I was not aware of those entries, nor had I ever been told of those entries or that Paul had such characteristics. Based upon those entries I would have expected the IPP for 1994 to set out a strategy to deal with that challenging behaviour. It a challenging behaviour such as fire lighting is identified either BIST or a client services psychologist would be contacted to develop a strategy to deal with the same. Paul did not appear to me to be a client with challenging behaviour. 1 was never informed that Paul was an arsonist or a fire-lighter or that there were any strategies in place to deal with such behaviour.[217]

Further, Mr Gungaphul was of the view that:

16 ... if a client handled the cigarette lighters or matches of staff members, even in their presence, the same should be reported in an incident report. Clients should be discouraged from playing with such items given their obvious dangers. If a client had a habit with playing with such items whether on their own or with other objects belonging to staff members or of a similar nature, then they should have been reported to the seniors so that appropriate strategies could be developed to discourage such behaviour. It is also my opinion that if a staff member has allowed a client to light a cigarette lighter and burnt his finger, then that incident should have been reported for the above reasons. Whilst there is no formal policy dealing with such incidents, at the very least, the direct care staff should have reported the matter to the Deputy Unit Manager or the Unit Manager to seek guidance on.[218]

215 Exhibit 258.

216 Exhibit 258.

217 Exhibit 258.

218 Exhibit 258.

Mr Stojan Kozaroska, Intellectual Disability Services Officer, who knew Paul well, stated:

> *3 ... When I first began at KRS in 1976, I was told by senior staff members that the year before Paul had burnt a painter's van. I have seen Paul play with cigarette lighters and matches and I have seen him light them, but I have never seen him try to set fire to anything. Generally, when staff members were talking Paul would approach them and if there was a cigarette lighter or match he would pick it up and light it. He would then show the staff member what he had done and say "good boy". I always believed that he was trying to show off to staff members and get their attention. Although I was aware of the rumour that he had set fire to the painter's van, I never thought Paul was dangerous and that he would in fact try to set things on fire. However, fire is dangerous and I had to be careful that he did not access cigarette lighters or matches.*[219]

Further, he stated that *'the only time I ever found Paul with a cigarette lighter or matches was while he was in the presence of staff members'*.[220]

Another carer who knew Paul well was Ms. Glenda McInnes, who saw him with a cigarette lighter or matches on two or three occasions. She stated:

> *4. There was a rumour that Paul had started a fire in a car at some time in the past. I do not believe there was any reference to the incident in the file. I don't recall any other incident of Paul lighting fires either personally or being told of the same. I believe that the source of the information concerning the car fire may have been the longer-serving, members of staff in the unit, but I cannot recall who. I placed some weight on the information told to me by the longer-serving members of staff even though it was only an allegation. There was no record made on his file as the information was not reliable.*[221]

Although Paul had the skills to light a cigarette lighter or matches, McInnes stated that:

> *[i]t was so rare for him to be seen with cigarette lighters or matches that I did not believe it was necessary to develop a strategy to deal with that behaviour alone. I considered it as part of his general behaviour of collecting sharp objects that one had to be concerned about ... Of course, if I came across Paul lighting the cigarette lighters or matches this would be different to the behaviour I had seen him exhibit and would justify appropriate strategies to deal with it.*[222]

In evidence, Ms. Vincent considered that:

> *I believe that Paul understood very clearly that a match or a lighter could produce a flame. I believe that he knew that that flame could be transferred because he would use a cigarette or a lighter – cigarette lighter – or matches to light a cigarette. And there was clear intent. He knew that that was going to light the cigarette. He obviously knew that he could burn other things with the cigarette because he burnt paper. But as to understanding the severity, the potential for that to escalate into a major life threatening thing, I don't believe he had the capacity to understand that. I think the concept was too complex for his level of functioning.*[223]

Further, she stated of Paul having the capacity to want to cause damage:

219 Exhibit 258.

220 Exhibit 258.

221 Exhibit 258.

222 Exhibit 258.

223 Transcript, p. 6316.

I don't know that it is as much to cause damage as just to play with the fire or to cause a fire.[224]

Mr Milan Krimpotic, who was also well acquainted with Paul, considered that:

[h]e is somewhat brighter than many of the other clients. In all of the time I have known Paul I have never seen him with or light anything with a cigarette lighter or matches or set fire to paper. Mary Lakic told staff that whenever Paul went out on a day program we should check his pockets when he returned. The reason for this is that he collects objects including glass and other dangerous items. I never saw Paul smoke a cigarette and I know that Mary Lakic did not like him smoking.[225]

Ms. Sally Andrews, Mental Retardation Nurse (MRN), was given the task of preparing the GSP in September or October 1995. Andrews stated that she consulted Mr Krist Boglis about the preparation of the GSP. Boglis has no recollection of the consultation. On the preparation of the document, Andrews stated that:

[w]hilst I would have relied upon the 1994 GSP as my starting point, I recollect that I only covered the mandatory life areas. I have recently been shown the GSPs of 1994 and 1995, the latter being the one that I prepared. I note that I have not dealt with the challenging behaviours referred to in the 1994 GSP, in particular those stated in the challenging behaviour inventory.

8. I do not recollect seeing that challenging behaviour inventory or the references to arson. Those references to arson do not accord with my knowledge of Paul at the time that I did the GSP. I had nor have I ever seen Paul light anything with a cigarette lighter or matches, nor have I seen him playing with a cigarette lighter or matches. I have observed Paul smoking with staff on two or three occasions but I had not even heard of any rumours of Paul setting fires.

9. I believe that if I had been aware of the challenging behaviours set out in the challenging behaviour inventory I would have made enquiries to ascertain whether Paul still exhibited those challenging behaviours and if he did I would have referred to them in the 1995 GSP. If he did not exhibit those challenging behaviours then there would have been no reason to include them in the 1995 GSP.[226]

Mr Boglis, an Intellectual Disability Services Officer, did not recall ever reading the file and said:

I have never been made aware of Paul's client profile or that there was an alert that he sets fires. It has also never been brought to my attention that the 1994 GSP makes reference to arson as a challenging behaviour exhibited by Paul. It was a surprise to me that such entries existed when I was shown the 1994 GSP. I would have expected to be told about these challenging behaviours when I worked with Paul and that there would be strategies in place to deal with such arson behaviour. I certainly never saw any conduct or behaviour by Paul to justify characterising him as a firelighter.[227]

Mr Boglis had occasionally observed Paul smoking. Evidently, he would approach staff members to finish off their cigarettes, and Boglis stated that:

I have also seen him, on a couple of occasions, pick up a staff member's cigarette lighter in the presence of the staff member. The cigarette lighter was taken off him immediately.

224 Transcript, pp. 6316-6317

225 Exhibit 258.

226 Exhibit 258.

227 Exhibit 258.

This was consistent with Paul's usual pattern of picking up objects and it did not appear to me that he had any particular fascination with the cigarette lighter or that he was attempting to light it.[228]

Mr Victor Goh, an MRN who worked in Unit 31 in about 1990, was the author of the 1990 'nursing notes' indicating that Paul had a history of setting fires. Goh was the Deputy Unit Manager, and he explained:

I never saw Paul with a cigarette lighter and did not see any incident justifying that entry. The reason for my entry in the nursing notes was that I was told by some staff members that he had a history of firelighting.[229]

Mr Goh also wrote a memorandum to Ms. Denise Harrison on 7 October 1990 stating that Paul had a '*[h]istory of setting up fires*'.[230] Apparently, this memorandum was sent to justify '*the locking of internal dormitory doors*'.[231] Goh stated that this reference also related to what he was told by others and that:

[a]n alert concerning Paul setting fire may have been generated as a result of my nursing notes or the memorandum I wrote ... but I am not sure. There were no incidents I could point to support my nursing notes or memorandum about Paul having firelighting behaviour. If Paul did have a history of setting fires, or was a risk in this regard, the GSPs or IPPs should have dealt with that issue.[232]

Many of the carers making statements also worked with Ms. Vincent, and they stated that she did not make them aware of the fact that Paul was said to be a fire-lighter or an arsonist. Equally, it is significant that a number of Unit or Deputy Unit Managers working in the unit after Vincent left indicated that they had read the file, were not aware of the fire-lighting issue, and consequently did not either inform other staff or commence an investigation. There is no evidence to suggest that the material Vincent prepared on the fire-lighting issue was not in the file at all relevant times.

In addition, Ms. Vincent pointed to an informal management practice:

It was my understanding that basically Paul's behaviour had been managed fairly informally over the years, particularly in regard to checking his pockets for objects of danger. It was a practice I believe that was passed verbally from staff familiar with clients, to staff that came to the units that were unfamiliar with clients. It was a practice that had occurred for over 20 years and it was a practice that occurred effectively for 20 years. And there have been assessments in regard to the other behaviours in a slightly different form.[233]

Ms. Vincent had made her assessment of Paul on viewing '*everything in totality*'.[234] But she also made the comment that she was told by staff, and a Unit Manager, that:

[h]e's picked up cigarette lighters and matches in the presence of staff, he's indicated that he can use these things, there are other occasions when people have found matches and lighters on him, other than myself, when he's returned to the unit I've been told

228 Exhibit 258.

229 Exhibit 258.5.

230 Exhibit 258 'VG2', para. 4.

231 Exhibit 258.5, para. 5.

232 Exhibit 258.5.

233 Transcript, p. 6317.

234 Transcript, p. 6387.

things by staff such as – I was told by the unit manager that I wasn't allowed to give him a cigarette because he would burn the unit down if I did. All of those sorts of things, are the sorts of things that I've taken into account, as well as the other entries that are in the client's file.[235]

The Parents' Association summarised its approach to Ms. Vincent's actions as follows:

Ms Vincent's recording of Paul as someone who might set alight a flammable item was based on the known association of him with the 1975 incident, her own observation of him setting alight to a newspaper at the Geiger Building with a cigarette. Her reference to the file notes prepared by Mr Goh, and her conversations with "old timer staff" who operated under an impression similar to Frlan's that Paul was someone who liked to play with fire. Vincent took into account that Paul liked to smoke, liked to acquire and hide dangerous objects including matches which she found on him on two occasions, and was known to be capable of forming the intention to transfer a flame without appreciating the dangerous consequences. All of this information added up to the fact that Paul was a person who needed to be very closely watched, and subjected to regular informal searching of his person and his bedroom. The procedure for searching Paul was one that Vincent believed was already in place when she prepared the 1994 GSP and was something she certainly expected to be referred to in the IPP. Unfortunately, however this did not occur. Vincent had no recollection of having sighted the 1994 Paul IPP, and said it must have slipped through.[236]

Ms. Vincent's Counsel, Mr Gilbert, in his submission on her behalf pointed to the fact that she prepared the 1994 GSP after consultation, that it was comprehensive and that she appropriately turned to 'oral history'. Indeed Professor Adler regarded oral history as being important.[237] As to the argument that the 1975 incident is 'a rumour', Gilbert pointed to the fact that Vincent was at KRS in 1975 and heard of the allegation at the time. Other staff were also aware of the allegation. It is suggested that there may be many explanations for the absence of an offender in the police report: '*for example, there was no real prospect that an intellectually disabled resident ... would be charged with arson. Alternatively Paul may simply not have been identified to police, to avoid repercussions for him or his carers'*.[238] There is, of course, another alternative: it was not Paul!

Mr Gilbert pointed to the fact that the documentation was done 18 months before the fire and is consistent with earlier documentation. Ms. Vincent had been in the unit for 18 months and therefore compiled the file with some knowledge. There was sufficient supporting evidence consistent with the assessment.

The Submission acknowledged that Ms. Vincent accepts that the preparation of the 1994 IPP for Paul was her responsibility to supervise. She '*accepts that it was deficient in that it should have had some specific reference to supervision of his habit of collecting things, as it was this area which carried the attendant fire risk'*. In addition there was no policy as to what should be included in the GSP or IPP. Apparently, it is '*is a matter of some debate whether it was necessary to put in the IPP, specific reference to fire lighting behaviour, as the IPP related to limited short term achievable goals'*. The GSP was the first document in time and a key reference for preparation of the IPP. At all times throughout the currency of the 1994 IPP, there was a resident alert referring to fire-lighting behaviour.

235 Transcript, p. 6386.

236 Parents' Submission, p. 65, para. 192.

237 Transcript, p. 5329.

238 Vincent Submission, pp. 1-2.

Staff had no training in assessment and managing fire risk behaviour. The training course on challenging behaviour did not refer to fire risk or fire-lighting behaviour.[239]

In addition Mr Gilbert makes the telling point that the 1993 renovations of Unit 31 did not result in the physical layout becoming a 'rabbit warren'. Vincent was working in a layout in which it was much easier to supervise informally Paul '*and monitor the activities of clients across all flats at the one time'*. Rather, it was the 1995 renovation:

> *which greatly increased fire risk by the creation of flats throughout the entire unit, making supervision and client observation more difficult, and hence a "rabbit warren". Vincent left the Unit soon after the preparation of the Paul GSP and IPP, before the 1995 renovation. She therefore did not have an ongoing relationship with Paul, whereby the adequacy of his IPP might come under her scrutiny, in the context of the changed physical layout of the Unit.*[240]

Further, it is significant that the review of the GPP in 1995 after Ms Vincent left the unit does not refer to fire-lighting behaviour. Gilbert submitted that:

> *[i]t is not open to conclude that because the subject was omitted, the earlier conclusion of Vincent must have been wrong or inappropriate. There is no evidence of any review or critical assessment of this aspect of the 1994 Paul GSP by the author of the 1995 GSP, so as to justify a conclusion that the earlier entries were no longer valid.*[241]

Finally, Ms. Vincent's Counsel said that a:

> *significant turnover of staff at all levels in Unit 31, both before and after the tenure of Vincent, must have had an impact on the flow of communication between staff. This, coupled with staff unfamiliarity with client files, is a systems failure, and cannot be laid at the feet of Ms. Vincent.*[242]

Following the fire, Paul was being managed by Ms. Terese Kenneally, an MRN. Ms. Kenneally did not give evidence but made a statement, in which she indicated that Paul would engage in staff-like tasks and mimic their behaviour. Her assessment was that Paul seeks to obtain items commonly carried by staff and wishes to have the same objects in his pockets as the staff. Kenneally stated that:

> *[w]hen one of the items he obtains is a lighter, it poses a risk because he has a natural curiosity and will play with it, and while he has the fine motor ability to light it, he doesn't have the cognitive skills to understand the dangerousness of it.*[243]

Of the references in the file to fire-lighting behaviour, Ms. Kenneally stated that:

> *[b]efore the entries in the file about fire-related behaviour were made, I would have expected that the author should have investigated the matter further to determine whether Paul's behaviours were isolated incidents or ongoing problems. If found to be an ongoing problem, then it would have been appropriate to refer the client to Client Services. The entries on the file seem to show isolated incidents.*[244]

The Unit Manager should have taken the following steps:

239 See generally Vincent Submission, pp. 3-4.

240 Vincent Submission, p. 5.

241 Vincent Submission, p. 5.

242 Vincent Submission, p. 6.

243 Exhibit 277, para. 10.

244 Exhibit 277, para. 12.

(a) make an entry in the file providing contextual information about Paul's behaviour, what is known and how the information came to be known;

(b) consult staff who knew Paul well about effective management strategies;

(c) update Paul's IPP to incorporate:

(i) the need for supervision and prevention of access to matches and lighters;

(ii) the need to keep Paul occupied with activities;

(iii) provide Paul with appropriate items to carry in his pockets which he associates with staff status;

(iv) identify areas in which Paul can be given responsibility; and

(v) encourage opportunity for positive interaction with staff, so that he relies less on inappropriate means to gain this;

(d) direct staff to report any further incidents so that Paul's behaviour could be monitored, and if the frequency or severity of the problem increased, make a referral to Client Services;

(e) ensure all staff were familiar with Paul's IPP; and

(f) adapt the environment to accommodate the IPP objectives, such as locking away lighters and matches.[245]

After viewing exhibits associated with Paul, Professor Robert Adler stated that the material was:

> *consistent with a person who is on the continuum from fire risk to fire play. In most adults the behaviours of themselves would not be of concern however in the case of a severely intellectually disabled person they are a cause for concern because of the potential dangers of playing with firelighting equipment by a person who could not be expected to anticipate the hazards of such behaviour nor to deal effectively with a fire if one were to begin. There is nothing in these descriptions that suggest that Paul was an habitual fire player nor that he ever exhibited a tendency to set fire intentionally with a view to causing damage or injury. The last would place him in the highest risk category, namely that of fire setting as opposed to fire risk or fire play.*[246]

He concluded that '*it would seem that Paul does not pose a serious risk of dangerous firelighting, meaning that there is nothing to suggest a history of aggressive behaviour nor a history of intentional or malicious firelighting'*, and that '*Paul is unlikely to intentionally set a fire, however, the risk of an accidentally started fire causing significant damage or injury cannot be completely eliminated'*.[247]

In evidence Professor Adler considered that oral history was crucial,[248] and said of the management:

> *Well, in relation to fire, I think, the first step IS to manage the environment, particularly, with young children or severely intellectually disabled persons and there are obvious steps that can be taken in that regard regarding access to lighters and matches. It is much more difficult with an adult who has freedom to go out of the institution, than it is with a child who is usually much more closely supervised by parents, so that there is the issue of access and that's partly staff themselves being careful about that if they do smoke not leaving lighters or cigarette – or matches lying around.*[249]

245 Exhibit 277, para. 13.

246 Exhibit 232, para. 13.

247 Exhibit 232, paras. 14-15.

248 Transcript, p. 5329.

249 Transcript, p. 5300.

But he stated that:

> *[t]here is no way of totally protecting even an environment, because things like toasters and other objects where – or the stove are still places where pieces of paper can be lit. I think that there is the issue of then looking at appropriate consequences if a young person or if an intellectually disabled person engages in such hazardous behaviours and they start from as simple as consistently saying: "No".*[250]

3.9.2 CORONIAL AND DEPARTMENTAL WARNINGS ON FIRE-LIGHTING BEHAVIOUR OR RISK

In January 1995, Dr John Patterson, former Secretary, Department of Health and Community Services, said in a memorandum to all staff (after discussing 'Staff Negligence' policy):

> *Fire Risk Behaviour*
> *Staff must take particular care where a client or family/carer is involved with dangerous behaviour with fire. Staff must discuss with the client/family/carers all reasonable precautions, including the use of smoke detectors, whether or not the client is living in their own accommodation.*
>
> *Where a young person is involved in risky behaviour with fire, staff should also consider a referral to the Metropolitan Fire Brigades' Juvenile Fire Awareness and Intervention Program or similar program offered by the Royal Children's Hospital.*[251]

In the THI Huot Ly and TRAN Moc-Qui inquests, the issue of fire-lighting behaviour of an 11-year-old autistic child was considered. TRAN Moc-Qui was eligible for Intellectual Disability Services, and his parents regularly sought assistance from Health & Community Services in managing his behaviour. The child set fire to his home in which both he and his mother, Mrs THI Huot Ly, died. On 2 March 1995, in the finding, the Coroner summarised part of the problem as:

> *The Health & Community Services Response*
>
> *It is difficult to understand how, between 1990 and 1992, an experienced government agency like H&CS could so clearly miss the point about fire and resultant risk to individual safety. 'Risk assessments' appear to have been a regular part of the responsibilities of H&CS workers. In spite of regular and detailed psychological assessments and reports, which frequently mentioned risk – fire and the obvious link to injury was not made. There has been some suggestion that the family did not specify a need to have assistance relating to the fire issue and that home inspection indicated the family were managing this behaviour. This suggestion misses the point. There was a misconception by department officers about the effectiveness of the family's fire management strategies which indicates the officers were working outside their field of expertise in assessing fire risk.*
>
> *Whilst the family did not apparently make the necessary early connection between fire and individual safety or serious property risk, the failure by H&CS to seek preventative advice from a specialist agency such as the Metropolitan Fire Brigade following clear notification of circumstances where individuals were at risk is difficult to rationalise.*
>
> *There has been comment that the understanding of fire safety issues by officers within H&CS has developed along with general community knowledge. However, the agency having accepted as part of its professional responsibility a 'risk' assessment, also has responsibilities to properly assess and advise. At the very least, having identified a potential hazard, it needs to direct its clients to agencies with required specialist knowledge.*

250 Transcript, p. 5300

251 Exhibit 270 in documents with 'End of Financial Year Report'. See also reference in the Tran Inquest.

In summary the failure by H&CS to adequately address the fire lighting issue may have related to the following factors:

(a) The general lack of community awareness of fire prevention issues.

(b) The concentration of H&CS psychologists and staff on behavioural related issues (as distinct from environmental).

(c) The lack of appropriate 'risk' assessment training for H&CS officers.

(d) Concentration by H&CS officers on the 'main' behavioural issue that of 'tantrums', and,

(e) The mistaken belief the family were managing the fire lighting behaviour.

However, following this fire, H&CS have developed strategies to avoid repetition of this type of incident. Those strategies also involve a recent general departmental direction as to risk and a specific direction dealing with fire. [Detailed reference was then made to Dr John Patterson's January 1995 memorandum, referred to in earlier comments in the KRS Inquest]. ...

It is important that systems failures be identified at an early stage and protocols developed. Recently H&CS have also been involved, as the lead agency, in developing an injury prevention strategy for Victoria (called 'Taking Injury Prevention Forward – Strategic Directions for Victoria 1994') which includes 'fire' prevention as one of the specific areas. The department is now working with the State's fire agencies and no doubt this integrated approach will assist in reducing the potential for incidents such as have been examined in this inquest.

In part, the Coroner made the following recommendations:

Recommendation 1
That the Fire Authorities and Health & Community Services consider a joint team approach to managing children with intellectual disability and fire lighting propensity (or fire lighting propensity alone). As family involvement and commitment is essential to maximise the potential for success of any fire intervention program a team approach may be of benefit.

As the officers from H&SC concentrated on issues associated with behavioural management and the relationship of behaviour to risk they failed to fully consider the relationship between behavioural and environmental factors. The professional methods of assessment of risk by the department where behavioural problems are being considered need review to include other factors.

Recommendation 2
That the Department of Health & Community Services consider developing a specialist training program to assist staff in identifying recent developments in modern hazard management strategies (see for example the program being currently developed by the Victorian Occupational Health & Safety Authority). Such a program would need to be suitable for the type of work undertaken by the Department.

During the hearing of the Tran inquest, Mr Gary Radler, Clinical Psychologist, Department of Human Services, gave evidence on the management of fire-lighting behaviour and the Behavioural Intervention Support Team's ('BIST') program. Radler was also the Acting Manager, KRS from February to August 1995. He also made a statement and gave evidence in the KRS fire inquest. He read Paul's file in preparation for his evidence, and stated:

14(b) It is my opinion that further investigation of Paul's fire-lighting history and current involvement in any fire risk behaviours should have occurred when the above references

were made or subsequently read by others in management positions. Such investigations should have included interviewing relevant past staff and the staff who were responsible for Paul care and support at the time. A search for relevant documentation should also have been conducted. Furthermore, it is my opinion that had such investigation led to any information that indicated any possible involvement with fire risk behaviour an action plan to address this should have been developed.[252]

As to the statement of Mr Pragnaratne, he stated:

15. I believe that the behaviour of Paul as described in the evidence of P. M. Pragnaratne should have occasioned further investigation about the extent of the behaviour when Paul was observed operating a cigarette lighter and placing his finger in the flame. The information obtained by such an investigation should then have been used to develop a plan of action which would minimise any perceived risk.[253]

Because of his experience in the Tran inquest, Mr Radler considered that he had a heightened awareness of the risks of fire-lighting behaviour.[254] His belief of the outcome of the inquest was that:

the Department should develop guidelines and training that assists BIST workers and client service workers to do risk assessments of clients referred to them who have a firelighting history. My understanding was not that all Departmental services should conduct risk assessments of all its clients with a possibility of fire risk behaviours.[255]

On 3 August 1995, Mr Radler circulated a 'Mental Health Services Program Management Circular' (signed by Ms. Jennifer Williams) on '*Fire Risk Behaviour – Reasonable Decision Making'* to all Unit and Sector Managers. In substance the circular repeats Dr Patterson's January 1995 memorandum, adding the need to seek specialist advice from areas such as the Metropolitan Fire Brigade (and the 'Juvenile Justice Awareness and Intervention Program') or a similar program at the Royal Children's Hospital. The document also provides some guidance on possible solutions such as smoke detectors.[256] It is noted that the 'Supervision Policy – 6 Lower Drive, November 1995' (for Building 37 Flats A to E inclusive) includes a '*Client Risk Assessment*' form. The printed form has headings for '*Epilepsy', 'Absconder', 'Wanderer', 'Allergies', 'Sunburn Prone'*, but there is no heading for fire risk or other challenging behaviours.[257] As the form does not flag 'fire-lighting' or 'fire risk' behaviour, it did not enhance the Williams circular.

In evidence Mr Radler agreed that it was fundamental for managers to receive training in 'risk assessment'.[258] He had no knowledge of any effort of management to make staff aware of the inadequacies of the system,[259] but he was aware of the increased risks to residents at night bearing in mind the reduction in staff.[260]

On the 9 April 1997, during the running of the inquest, DHS appropriately recognised a number of deficiencies in its systems. As to the fire-lighting risk issue, the Department commented (in part):

The following deficiencies in systems and for procedures have been identified as pertaining as at the time of the fire. None of these deficiencies contributed to the cause of the fire.

252 Exhibit 258.1.

253 Exhibit 258.1.

254 Mr Radler also had personal experience of fire which heightened his awareness: see Transcript, p. 6481.

255 Exhibit 258.1.

256 Exhibit 258.1 – Annexure 'J'.

257 Exhibit 78.

258 Transcript, p. 6501.

259 Transcript, p. 6484.

260 Transcript, p. 6508.

1. RECORD KEEPING

The Department of Human Services acknowledges that the standard of record keeping in certain areas at Kew Residential Services at the time of the fire required improvement. The approach to the collection, recording and maintenance of information whether current or historical, has not been as comprehensive or accurate as it should have been.

The Accommodation Services Filing System introduced in June 1995 and the new computerised Client information system, currently being introduced, known as "DISCIS" both address client information recording.

The Accommodation File ensures all relevant information in relation to an individual client is contained in one location and that GSPs and IPPs are readily accessible.

DISCIS and the "Assessment of Needs Report" make provision for current behaviours to be recorded as an "alert" and behaviours which are no longer current made " inactive".

2. GSP/IPP STAFF AWARENESS AND SUPERVISION

Department of Human Services acknowledges that at the time of the fire staff at Kew Residential Services had not been as familiar with the contents of clients' files as was desirable and that a more active approach to dissemination and promotion of client information was required. Furthermore, the preparation of documents was not thorough and supervised as necessary in all instances.

The preparation of all important documents concerning the client should be thorough and overseen by the Unit Manager. Where the Unit Manager delegates GSP and IPP preparation, the Unit Manager should ensure that the staff member has the necessary skills and that appropriate quality checks are put in place including supervision and "sign off' by the Unit Manager. ...

5. Assessment and Management of Clients with Fire Lighting Risk

The Department of Human Services acknowledges that at the time of the fire the approach to assessing and managing clients who were a fire lighting risk was not as comprehensive or as expansive as required nor was the approach incorporated into the department's systems.

In responding to the recommendations of the inquest into the death of Moc Qui Tran the department's approach was confined to clients who had a known propensity for fire lighting. In following this approach the assessment of clients was limited in scope. While the department generally alerted staff to the need to identify clients with behaviour which may pose a risk it did not adequately systemically embed this approach into some of the main practices and procedures of the department.

Since 1996 the approach taken by the department has been broadened. The approach has addressed the issue on two levels. First the assessment process has now been expanded to include clients who have a known propensity to light fires and now includes clients who are a fire lighting risk due to their reduced cognitive functioning and limited physical independence skills.

Secondly the guidelines and instructions are either now, or soon will be (as indicated below), embedded in the established systems within the department. This more systematic approach includes:

- *Expanded Assessment of Need which includes prompts for case managers to better assess a clients fire lighting risk (completed)*

- *New Practice Instructions for residential workers to assist them in identifying any risk factors (in the process of being finalised)*
- *Advice sheets for families and residential workers on how to reduce risk by addressing the physical environment and client behaviour (family sheet finalised, staff sheet in process of being finalised)*
- *Identification of service options for clients who have behaviour which is a fire risk (finalised)*
- *Assessment and planning guidelines have been built into the Induction Training and the Managing Challenging Behaviour Training (finalised)*
- *Negotiations are currently underway to develop a package for staff working in the Behaviour Intervention Support Teams*

It should be noted that the range of skills and personalities of people with an intellectual disability is as diverse as that of the general community. The objective is to create a situation where staff are aware and informed as well as better skilled to make assessments and develop programs and approaches for the individual.

In implementing this objective the emphasis of the Department has moved from response to those individuals with demonstrated fire lighting behaviour to focusing on the assessment of potential fire risk behaviour. This necessarily includes a much larger group of people who require proactive strategies to prevent actual instances of fire lighting. These strategies may require:

- *Management of the environment such as limited access to, and security of, flammable materials, security of lighters by all smokers and provision of appropriate safety equipment such as smoke detectors, extinguishers and fire blankets.*
- *Safety of appliances used by individuals with greater independent living skills.*
- *Close scrutiny of individuals who collect or hoard items to ensure no hazardous materials are collected.*

Referral to appropriate programs to change at risk behaviours such as MFB/CFA Juvenile Fire Awareness and Intervention Program or BIST.[261]

Earlier, during the running of the inquest, the Department made a number of concessions about systems problems. One of the areas dealt with was 'fire-lighting risk or behaviour'.

In the context of critically examining the actions of staff in assessing potentially challenging behaviour problems, it is important to bear in mind the changes that were occurring in Building 37 from 1993 onwards. Staff were faced with some difficulties, which are summarised in the Villamanta Submission as:

Unit 31 went through significant upheaval during and after amalgamation with Unit 30 ...:

1. Management – staff dispute over the amalgamation;

2. The size of the unit exceeded the usual size for one unit manager to oversee (Statement of Francine McCartin, 4 p.11:

3. The renovations to Unit 31 during 1995 where unit 31 residents were housed elsewhere;

4. Appointment of 4 Unit Managers or Acting Unit Managers from November 1994 unit the time of the fire.[262]

261 Exhibit 267.

262 Villamanta Legal Service Submission, p. 52.

3.9.3 CONCLUSION ON THE MANAGEMENT OF FIRE RISK BEHAVIOUR BY DHS

The MFB Submission essentially argues that there was a failure to properly manage Paul. It makes the following points:

- All disabled persons with the necessary motor skills to light a fire are a potential fire risk because of their inability to understand the consequences of their actions;
- There was a body of written evidence and oral history showing that Paul was a significant risk in terms of fire risk behaviour or fire-lighting behaviour; and
- Paul hoarded objects and kept them secretly in his room, and he was previously observed playing with fire lighters as he did on the day of the fire.[263]

The central issue in this fire incident is the effective and practical management of risk. The reasoning behind this theme can be seen in the Public Advocate's Submission to the effect that:

> *[a] key element of the minimisation of the risk of fire is the effective and sophisticated management by carers of persons who might have the propensity to cause risk. As would be true of any proportion of the population, the grouping together of a large number of people will include individuals who display behaviours that may cause risks. Such behaviours may pose a threat to others in the group, some may pose a threat only to the individual himself or herself. The evidence establishes that many residents at Kew Residential Services displayed challenging behaviours.*[264]

This submission summarises well the type of general practical philosophy behind what should have happened. Unfortunately, it did not happen.

The fact that the issue of fire-lighting risk was not properly managed has been recognised by DHS in its various concessions at the inquest. In summary DHS acknowledged, prior to staff giving evidence, that:

- *Record keeping required improvement and the approach to collection, recording and maintenance was not as comprehensive or accurate as it should have been;*
- *Staff were not as familiar with the contents of files as was desirable;*
- *Unit managers should supervise the preparation of all important documents such as GSPs and IPPs. The staff member should have the skills to perform the task;*
- *For Building 37 there was not a comprehensive handover of managerial duties from one unit manager to another;*
- *The approach to assessing and managing clients who were a firelighting risk was not as comprehensive or as expansive as required.*[265]

It must be acknowledged that these concessions are appropriate in the light of the material before the inquest.

The State of Victoria's Submission examined the issue of the distinction between 'fire-lighting behaviour' and 'fire-lighting risk'. It argued that '*[t]here is no or no sufficient basis to support Ms. Vincent's conclusion that Paul had exhibited firelighting behaviour as distinct from being a fire lighting risk'*. It is critical of Ms. Vincent on a number of points and urged that '*there were*

263 MFB Submission, p. 77, para. 153.

264 Public Advocate's Submission, p. 84.

265 State of Victoria's Submission, pp. 137-138.

unsatisfactory features of Ms. Vincent's evidence which bear on her credibility'. Having observed Vincent in the witness box, this view of her credibility is not shared.

The distinction between 'behaviour' and 'risk' is a nice point and may require some degree of training in identifying risk behaviour as distinct from situations of risk to enable the researcher to recognise the difference. The Submission also fails to recognise one of the concessions: *'The approach to assessing and managing clients who were a firelighting risk was not as comprehensive or as expansive as required'*.[266] Vincent had not been trained in risk assessment when she started to collect and record some of the incidents in which Paul was involved. This was one of the main points in the Tran inquest – *'risk management training for staff'*. Apparently, after Tran, no risk management training highlighting fire was given to staff.

Ms. Vincent recorded the information on Paul well before the Tran case and directions from DHS about managing fire-lighting behaviour. Unfortunately, she did not continue to investigate what had been recorded. Vincent considered that the search regime was sufficient to manage Paul.

The point was also made by the State of Victoria that Ms. Vincent did not undertake further investigations and did not advise other staff. Nor did many others who later read the file. Those people included Unit managers. A senior member of staff was made aware of the 1975 rumour well before Vincent's documentation, but no action was taken to investigate.

If Paul's behaviour should have only been regarded as 'fire-lighting risk', the logical extension of Tran – from managing 'fire-lighting behaviour' to managing 'fire-lighting risk' – was also not fully recognised by DHS at the time. It is now. Because of this the issue was not managed. The necessary programs were not put in place to assist staff with the difficult task of managing challenging behaviour in this area. In the context of a well-identified inadequate fire safety system at KRS, the importance of managing this area of risk is obvious. It was also obvious before the fire.

Further, a number of managers and staff had the opportunity to read or review the file after Vincent. Many did not. Those who did either did not see or (perhaps) did not consider the comments to be significant. It is difficult to understand the focus on the individual – Ms. Vincent – in a system identified as being faulty when many others made similar errors.

The State of Victoria by its agent DHS failed to manage fire-lighting risk at KRS. In particular it failed to manage the fire-lighting risk posed by Paul.

3.10 SMOKING POLICY AND ITS EFFECT ON FIRE RI SK

Along with the management of fire-lighing risk or fire-lighting behaviour in the context of an inadequate (unsprinklered) fire safety system, it was necessary to review the smoking policy at KRS and the availablity of fire lighters. Undoubtedly, because the issue of 'fire-lighting risk or behaviour' was not considered, such review was not undertaken.

3.10.1 POLICY

While it is recognised that policy direction is moving towards assisting intellectually disabled residents to live as normal a life as possible, in the context of a fire unsafe building a smoking policy needs to be very carefully assessed. In respect of residents who do not appreciate the risk of fire and who may be difficult to evacuate, the Parents' Association argued that there is *'an underlying*

266 State of Victoria Submissions, pp. 137-138.

sense in which intellectual disability gives rise to a general need to manage risk behaviours'.[267] Further, the Association said that '*smoking amongst staff and clients presented an ongoing potential for the general risk to be realised'*.[268]

In evidence Mr Dibben indicated that he was aware that there were *'active and anti-smoking campaigns, or programs there to prevent smoking within buildings ... but with the level of supervision ... it was my belief ... even with the pronounced and accepted anti-smoking campaigns the clients couldn't be policed a hundred percent of the time'*.[269] Mr Lai suggested to KRS that clients and staff not smoke in units, as evidence of smoking was found during surveys.[270] Occasionally, Mr Frlan discovered cigarettes and lighters in the kitchen of Units 30/31.[271]

It appeared that both staff and residents smoked and that there was no attempt to evaluate residents who may require special safeguards to be put in place. Residents such as Paul '*used to smoke if he could'*.[272] Mr Wales would have been concerned if Paul had left a cigarette somewhere. He would have preferred that Paul did not smoke,[273] and he noted that '*[w]hether a client could smoke was not always on their GSP/IPP'*.[274]

The Parents' Association Submission made a telling point:

> *after the fire in consultation with sector managers, arose from the high number of challenging clients in units 26/27, many of whom smoked or had a shown interest or involvement with firelighters in the past. Some of the identified clients had even been responsible for causing actual fires in the past, but it is not apparent that any steps were taken to inform staff generally as to potential risks associated with those clients prior to the fire.*

Further, the Association stated:

> *In fact, it is not even apparent that any consistent approach was adopted prior to the fire to ensure that this vital information was contained in the subject's file, and in the case of the two clients who set fires in wardrobes in 1994 and 1995 ('Q' and 'W') only one of them had the information on his file prior to the fire.*[275]

The Parents' Association Submission pointed to the Willsmere inquest in 1968 and the Deputy Coroner's comments in the 1991 Leige Court and Athol Lodge fire inquests that '*[c]oncern has been growing for some time now at the risk of fire in special accommodation houses. In the Annual Report of Community Visitors for 1991 the issue of smoking and fire safety in supported residential services was raised'*. It noted that the Melton Court fire was started with a resident's cigarette. The Submission continued, stating that:

> *[c]learly other environmental factors impact on a full risk management of a residency such as KRS including the building age and fabric, the fire response hardware, staff ratios etc. However, even if all the other variables could be gainsaid, awareness of the risk of client or smoking related fire should be a special component of risk management undertaken by management and accorded special priority.*[276]

267 Parents' Association Submission, p. 42, para. 120.

268 Parents' Association Submission, p. 42, para. 120.

269 Transcript, p. 2906.

270 Transcript, p. 2958.

271 Transcript, pp. 2418-2419.

272 Transcript, p. 1702 (Mr Wales).

273 Transcript, pp. 1702-1703.

274 Transcript, p. 1809.

275 Parents' Association Submission, p. 47, paras. 125 (c), (d).

276 Parents'Association Submission, p. 50, para. 133.

The failure to identify and manage resident fire risk in an environment where smoking was permitted was a recipe for problems. Where this failure occurs '*against the backdrop of an inadequate fire safety system'*, the potential for disaster is magnified.

3.10.2 AVAILABILITY OF CIGARETTE LIGHTERS AND MATCHES: A RISK ASSESSMENT

Many staff smoked during their breaks, and thus lighters and matches were brought on to the complex. The Kew Cottages & St. Nicholas Parents' Association Inc. operates a kiosk at KRS, which is staffed by paid employees during weekdays and volunteers on weekends. In a report dated 8 November 1996, the Association indicated that:

> *[p]rior to the fire the kiosk sold cigarettes, matches and lighters all of which were available to staff and some residents. As to residents, about twelve are known to buy cigarettes, matches or lighters. However, staff and volunteers use their discretion concerning sale to residents, ie: residents must be recognised as smokers, be able to indicate their purchase and have the money to make a purchase. Those residents who make such purchases at the kiosk usually attend the kiosk unattended.*[277]

The Kiosk policy has since changed to prevent the sale of lighters to residents. However, '*cigarettes and matches remain available'*. The new policy is by way of a verbal instruction to staff and volunteers.

In the context of an inadequate fire safety system, the smoking policy at KRS should have been reviewed. A review would have considered the general sale, supply and use of fire lighters within the complex and at the Kiosk. It would have identified other ways of managing and reducing the risk, for example, by the use of childproof cigarette lighters.

3.10.3 CHILDPROOF CIGARETTE LIGHTERS

By 1995, childproof cigarette lighters were available in Australia. Recently, the Ministerial Council on Consumer Affairs considered the need for a national approach to the issue of safety of disposable cigarette lighters. A safety standard was introduced covering construction and performance of lighters. Child resistant features are also required. The standard took effect from 1 July 1997.

There is an obvious, but difficult, balance between the rights of the intellectually disabled to live as normal a life as possible and the requirements of safety. Nevertheless, in the context of a fire unsafe situation such as applied at KRS before the fire, the use of childproof cigarette lighters may have been of some assistance.

3.10.4 CONCLUSION

The failure to adequately manage the smoking policy and the availability of fire lighters within the KRS complex is but an example of the general failure to manage fire-lighting risk by the State of Victoria through its agent DHS.

3.11 USE OF FIRE RESISTANT FURNITURE, BEDDING AND MATERIALS

The importance of care in the selection and use of furniture, bedding and materials can be observed by the MFB 'fire test' at Port Melbourne. Also it is noted that the Royal Children's Hospital recently commissioned a consultant to test various bedding, fabric, furnishings, electrical equipment, etc.

277 Exhibit 81.

for flammability. Some of the results were provided to the inquest. However, there was no evidence to suggest that inappropriate bedding and furnishings were used in Flat E, Unit 31. There was no evidence of any additional material having added to the fire load.

The windows used in Unit 31, Flat E, were made of polycarbonate which is highly flammable. An aluminium shutter screen was drawn on the outside of the windows. The MFB Report summarised this aspect of the building thus:

> *[t]he windows throughout Building 37 were glazed with polycarbonate sheet of thicknesses varying between 4.5 mm and 6 mm thickness. The windows were also fixed with limit stops to restrict the distance by which they could be opened. The windows were covered with security aluminium shutters.*[278]

In its Submission, the MFB made the point that:

> *[t]he circumstances of the fire also carry important lessons in regard to the maintenance of unsprinklered secure premises. It may be accepted that in some situations it is necessary to provide care for clients in such premises, although no doubt only where this is absolutely necessary ... it is not uncommon ... for there to be bars on windows and for there to be polycarbonate glazing on windows.*[279]

The use of flame retardant building materials is also discussed in the Findings in P**ART 5 Building Lae and the Fire 5.2 Alterations to Building 37 and Unit 31: Effect on Fire Safety.**

3.12 AUTOMATIC DOOR LOCKING/RELEASE SYSTEMS

At KRS, Unit 31, Flat E, was normally locked during the evening. As the evidence suggested that some of the internal/external doors were locked during the fire, this may have created a problem for the residents if they had had the capacity to exit the flat themselves. The problem with locked doors during a fire emergency was discussed during the inquest into the six deaths during the Willsmere fire in 1968. Major Snelling remarked that '*[t]his could have meant that somebody might have escaped through that door and perhaps not so many people would have lost their lives'*, although Snelling appreciated the need for security.[280] DFO Anderson, MFB, stated:

> *I would agree with Major Snelling – this building was a fire hazard. In my view the locking of the door at one end of the building could have contributed to the risk that was involved inasmuch as it would have made the removal of patients more difficult only having one entrance, and they may have had to pass the fire to get patients out that particular entrance.*[281]

The Sister in Charge, Ms. Gurr, also agreed that the western door was locked from the outside as it '*is normal for the doors at one end to be fastened to stop patients wandering out of the ward'*.

Historically, problems with security persist to create difficulties for fire safety and evacuation in an emergency. In the fire on 8 April 1996, a number of doors to Flat E were locked during the night. Unit 31 is a locked unit. Apparently, the locked door policy for the unit was developed to contain one resident.

The MFB encountered difficulties during the evacuation. For example, as the doors were not all opened by KRS staff, brigade officers had some trouble in gaining access:

278 MFB Report, p. 29.

279 MFB Submission, p. 116, para. 206. See also discussion in the Findings in **PART 5 Building Law and the Fire 5.2.1 Construction of Building 37 and Unit 31.**

280 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, pp. 16-17.

281 Coroner's Brief – Police Arson Squad – Willsmere Inquest File, p. 32.

Mr O'Keeffe could not access doors 48 and 39 (T686). He tried to kick these doors in but failed (T679) and no one gave him any keys (T680). Mr Morris confirmed Mr O'Keeffe's evidence (T964).[282]

The doors in Units 30/31 did not unlock automatically in case of a fire. Other units at the complex – 13/14, 17/18 and 19/20 – had automatically unlocking doors, but they were not linked to the existing fire protection system. During the upgrade, 13/14 were connected to the system. The Building Code of Australia makes special provision in the case of security:

(c) serves an occupancy where special arrangements for security are necessary and it can be immediately unlocked:

(i) by operating a fail-safe control switch not contained within a protective enclosure, to actuate a device to unlock the door; or

(ii) by hand by a person or persons, specifically nominated by the owner, properly instructed as to the duties responsibilities involved and available at all times when the building is lawfully occupied so that persons in the building or part may immediately escape if there is a fire or other emergency; or

(d) is fitted with a fail-safe device which automatically unlocks the door upon the activation of any sprinkler system or smoke or heat detector system installed throughout the building.[283]

It is noted that in 1986 the MFB made recommendations on automatically unlocking doors.

The Parents' Association argued that:

in the case of Units 30/31 at the date of the fire, the evidence pointing in favour of the critical need for automatic locking doors or increased staff numbers is even more conclusive. The renovation of the building into a labyrinthine configuration of five decentralised flats, together with the absence of local alarm sounder at the unit, an effective smoke detection system and sprinklers meant clients were very dependent on staff achieving evacuation in the minimum time.[284]

A report was provided after the fire by Warrington Fire Research on 'Automatic door locking/ release systems' for use in premises where persons with an intellectual disability are housed. The Warrington Report stated that '*locking release systems form part of an overall fire safety strategy and the suitability should therefore be considered in conjunction with other fire safety sub-systems'.*[285]

The Submission of the Public Advocate suggested that in view of the 'very low' night staff-resident ratio of 1:23:

the most effective method of controlling the movements and supervision of residents was to lock at least the doors between the adjoining flats. This in turn had the potential to reduce or confuse the expectation that a resident might have had that a particular door would provide a means of egress. It increased the potential for a frozen response on the part of residents when faced with the need for urgent egress. In addition, it necessitated a greater degree of reliance on human intervention in order to open the doors in the case of a fire.[286]

282 See MFB Submission, p. 41, para. 96.

283 Building Code of Australia 1900, Part D2. 21.

284 Parents' Association Submission, p. 29, para. 81.

285 Exhibit 284, p. 6.

286 Public Advocate's Submission, p. 126.

The Warrington Report posed some of the difficulties for automatic locking systems in this type of environment when it concluded that:

> *6.1 Whether manual or automatic locking methods are adopted staff involvement would be required to facilitate an effective evacuation.*
>
> *6.2 Automatic locking/release arrangements may assist in the evacuation process but they may also have side effects which need to be addressed in emergency procedures.*
>
> *6.3 The door locking/release strategies for facilities such at Kew Residential Services need to address absconding clients and the potential for clients to re-enter the building during a fire emergency in addition to providing unobstructed egress routes.*[287]

Automatic door locking mechanisms may present difficulties in situations where intellectually disabled persons are accommodated. However, those difficulties are capable of being managed.

In this incident it is probable that the residents would have survived with an operational smoke detector system in the bedroom of fire origin, combined with an efficient response of the staff. However, on the night of the fire, even given exit doors linked to the fire alarm system which automatically unlocked on alarm, it would still seem unlikely that any of the residents would have survived (in view of the late alarm operation). Nevertheless, that reasoning does not justify the failure to consider properly the installation of an automatic door opening system, in light of the existing inadequate fire safety system at the time of the fire.

3.13 STAFFING RATIOS FOR FIRE EMERGENCY

3.13.1 INTRODUCTION

In view of the '*lack of faith*' in the ageing and inadequate fire safety system, staffing levels for night-time fire emergency, as an interim solution, required review. This did not occur. The many reports on fire safety at KRS refer, in varying degrees, to night-time difficulties. Once it became obvious that 'interim' hardware solutions were not going to be an option, management had a more urgent requirement to review staffing levels. The 1995 renovations to Unit 31, Flat E, added to that urgency by creating a more complex environment to supervise and manage in an emergency with low staff/resident ratios.

Staffing at KRS was divided between regular and after hours work. For the purpose of this investigation, issues associated with the staffing levels during normal business hours have not been examined. The issue for the inquiry involves staffing levels after hours. Suffice to say that staff numbers are considerably greater during business hours.

After the fire DHS commissioned an independent assessment of staffing levels and fire safety. This assessment was conducted by Warrington Fire Research.

Again the statement of Mr Winn, one of the authors of the Dibben Report, highlights the importance of staffing levels in the context of well-identified inadequacies in fire safety. He noted that he received '*excellent cooperation and support*' from Taylor, Vasan and supervisory staff. On Vasan's involvement, he stated:

> *I particularly found Srini Vasan to appreciate that there were deficiencies in the quality of procedures and some equipment and documentation, and found him anxious that*

287 Exhibit 284, p. 6.

improvements be made at Kew. Srini Vasan specifically expressed his concerns about staffing levels at night and that this together with their lack of training would provide difficulty in effecting evacuation of residents in an emergency.[288]

The fact that KRS's maintenance engineer was well aware of the risk even before the ULA Report is telling. Mr Taylor also had a '*lack of faith'* in the existing system. With the renovations in 1995 changing the layout of Unit 31, the importance of addressing staffing issues should have been obvious to management. They had already recognised the problem, especially at night.

3.13.2 AFTER HOURS

Apparently, there were no statewide guidelines for staffing levels. Mr Arthur Rogers, Regional Director, Eastern Metropolitan Region, stated that:

[t]he service models and client support needs are so diverse that staffing levels, both during the day and at night, must be necessarily determined by local management, taking account of client support needs, duty of care obligations, available resources and industrial considerations.[289]

However, Mr Rogers did point to a number of '*state-wide initiatives and practice instructions'*.[290]

It is understood that the after hours staffing ratios for each unit varied between weekdays and weekends. On weekdays there was one staff member on duty between 4.30 p.m. and 8 p.m. Between 8 p.m. and 7 a.m., there were two members of staff on duty. One staff member was on duty between 7 a.m. and 8.30 a.m. For Units 30/31 there was an additional staff member on duty between 4.30 p.m. and 10 p.m. five nights a week to relieve the pressure on night staff. There was no additional staff member for the remaining two nights. There was an After Hours Co-ordination Team (AHCOT), which comprised:

one MRN 3 or MRN 4 staff member on between 4.30pm and 9.00pm.

There are two MRNs on between 9.00pm and 7.00am every night.

Both AHCOT staff spend the majority of the shift visiting units.[291]

On weekends there was one member of staff on duty between 7 a.m. and 8.30 p.m. The night (after hours) duty team remains the same as for weekdays as does the early morning duty.[292]

Following concern expressed by Mr Taylor about the lack of local alarms and the fact that seven (7) units would '*only learn of an alarm as a result of advice from the administrative block and the arrival of the MFB*', a member of staff was allocated to '*constantly monitor the alarm board until the upgrade was completed'*.[293] Mr Eyre, former Unit Manager of Units 30/31, had:

some major concerns about the viability of night evacuations in the event of fire. I raised those concerns with my Line Managers who were Pat Kelly and Denise Harrison. I was

288 Exhibit 299, para. 11 (emphasis added).

289 Exhibit 213 – Mr Roger's statement, p. 2, para. 8.

290 Exhibit 213 – Mr Roger's statement, p. 2, para. 9. In 1992 funding was provided for an additional 24 staff '*for unit managers to be super-numerary to unit staffing and the establishment of the role of Night Services Co-ordinator with clearly specified responsibilities for after hours care*'. Thus after 1992 the Unit Managers were not included in the direct care staffing numbers for each unit.

291 Exhibit 213 – Mr Roger's statement, p. 3, para. 11.

292 See Coroner's Brief – Police Arson Squad, pp. 236-247 (Ms. McCartin's statement).

293 Exhibit 159, p. 14.

informed that no more staff could be provided for that purpose due to budget constraints. I believed that two staff to evacuate 52 men would be insufficient.[294]

Apparently, although night drills were conducted in the unit, Eyre:

had doubts as to their effectiveness as staff always knew that they were only hypothetical and due to a reduced level of panic clients tended to be more compliant than they would have been if in fact there was a fire.[295]

Mr Wales also expressed some concern about night-time drills in Units 30/31 when he said in evidence during questioning:

Question: Do you remember having a drill at 30/31 after which you and Ann Fisher discussed it, and expressed the view that it was going to be terribly difficult to ever get the clients out of there if there was a fire?

Answer: I remember discussing with somebody it was more difficult than the straight line units to evacuate people from the flat set up.

Question: Of course, the changes that were brought about in the units, and in particular in unit 31, made it so much more difficult to evacuate such accommodation areas than was the situation under the old dormitory, or the previous style of accommodation? Answer: Yes, because with the dormitory style everything was in a straight line.

Question: Whereas under the new conditions it would not be unfair to describe them in terns of evacuation as constituting rather something of a rabbit warren?

Answer: Those words were used by some people, yes.

Question: You didn't disagree with them as being a fair description in those terms?

Answer: No, not really.[296]

Ms. Noter, who had worked in Unit 30, was also concerned for the following reasons:

Answer: ... Yes, and then I worked when they amalgamated with D Flat – E Flat, which used to be 16 clients together.

Question: So did you work there at a time when the bedrooms were more of a dormitory situation than they subsequently became?

Answer: Yes.

Question: Would you agree that if you were working nights, than in the separate flats?

Answer: Yes.

Question: But the breaking of the building up into flats certainly helps with challenging behaviours, doesn't it?

Answer: Yes .

Question: In that the clients aren't all crowding around together in the middle of a dormitory type structure?

Answer: Yes.

Question: But, on the other hand, breaking it up into many rooms, into a many roomed unit, means a greater need for supervision?

294 Exhibit 258.

295 Exhibit 258.

296 Transcript, p. 1793. See also discussion in the Transcript, p. 1797 (Wales); p. 2432 (Frlan); pp. 2467-2468 (Free on difficulties with night evacuations); p. 1595 (Stanisavljevic); pp. 2798-2800 (Caracher).

Answer: Yes.

Question: And therefore perhaps more staff?

Answer: Yes.[297]

3.13.3 EXPERT OPINION ON NIGHT STAFFING LEVELS FOR FIRE EMERGENCY

In 1992 the Lumley Report commented under 'Emergency Evacuation Drills' that '*staff to client ratios during night shift varied from 1-8 to 1-30 and that night staff were required to conduct half hourly rounds. Should an emergency arise coupled with a power failure at night, we question the effectiveness of an evacuation from the larger and multi storey units such as Unit No's. 1, 7 & 8'*.[298]

In 1993 the Dibben Report (which was not seen by KRS management) warned that '*[t]he greatest exposure of the Department to an emergency is during the after hour periods where 40 direct care staff only are on duty'*. When dealing with 'Evacuation and Emergency Procedures', Dibben also remarked that if:

> *a fire occurs out of hours, the high probability of rapid fire extension in most buildings will cause a grave situation. This will be exacerbated by the low staff levels and time and space (distance people need to travel to the scene).*[299]

Finally, the ULA Report under 'Evaluation of Analysis' suggested that the time lines indicated that the existing fire safety system provided sufficient warning for staff evacuation of occupants in all areas except for sleeping/dormitory. However, in sleeping areas with high fire load, the Report stated that:

> *limited fire detection and lack of local fire alarm warning within the units means these areas are a potential threat to the clients. Time line analysis for a sleeping area fire indicates that insufficient time will be available for the staff to evacuate the clients, even with earlier detection through the use of smoke detectors.*[300]

Further, under the heading 'Fire Safety Audit', the ULA Report made the point that '*reducing numbers of staff lowers the probability of satisfactory staff response to an emergency'*.[301]

After the fire, Mr J. England of Warrington Fire Research provided a report on Staffing Levels for DHS. Warrington examined the potential role of staff during a fire emergency and opined that *'[d]uring a fire emergency the staff and clients can be considered to form part of an overall fire safety system for the building'*. Significantly, Warrington opined that the:

> *extent and speed of evacuation required and subsequent ability to manage the clients necessary to achieve a satisfactory level of fire safety, would depend on the other fire safety measures provided which make up the total fire safety system.*
>
> *The adequacy of staffing levels has been considered with respect to the fire safety upgrade package which was being undertaken at the time of the fire. The effect staffing levels may have had on the consequence of the fire which occurred on the 8 April 1996 have also been considered.*[302]

297 Transcript, p. 1384.

298 Exhibit 53 – Lumley Report, p. 25, para. 3.2.

299 Exhibit 54 – Dibben Report, p. 6.

300 Exhibit 143 – ULA Report, p. 17.

301 Exhibit 143 – ULA Report, p. 7.

302 Exhibit 283, p. 3.

Warrington examined the resident profiles of the 46 residents of Units 30/31, and concluded that staff would have had to assist not only in the evacuation but in preventing re-entry into the building.

At the time of the fire, there were two staff responsible for the 46 clients (a ratio of 1:23). With the addition of an extra 35 staff and two night coordinators, the ratio reduces to 1:16. The Warrington Report stated:

> *Fire emergency procedures were in place on the 8 April to bring staff from other units to assist during a fire emergency. On the night of the 8 April a preliminary estimate indicates that approximately 5 minutes after the alarm, at least four additional staff members were on the scene, making the staff to client ratio approximately 1:8 for units 30 and 31, with additional staff also responding later.*[303]

After examining the fire drills and response times, Warrington concluded that '*evacuation is feasible with initial client to staff ratios up to 23:1 but the speed of evacuation would be relatively slow*'.[304]

The Warrington Report on Staffing Levels also examined various regulatory or performance-based codes on staffing. Evidently, the Building Code of Australia does not provide any guidance on staffing levels and fire safety. Although the Victorian Health Services (Residential Care) Regulations 1991 (section 511(1)) provides some guidance on staff/resident ratios, these regulations do not apply to KRS. However, the regulatory requirement for staff numbers at night is as follows:

> *(i) at least one special or personal care provider is on the premises and readily available during an emergency; and*
>
> *(ii) sufficient staff are available to enable the premises to be inspected to ensure the safety of those residents who have difficulty in calling for assistance.*[305]

Other requirements considered were: the 'NFPA 101 Life Safety Code' and the 'NFPA 101A Guide on Alternative Approaches to Life Safety' (United States of America); and the Building Regulations 1991 (England and Wales) and Building Regulations (Northern Ireland) 1994. After considering the regulations and codes in Australia and from overseas, Warrington concluded that:

> *[a]ppropriate staffing levels to achieve a particular level of fire safety are dependent upon the overall fire safety strategy: ie. lower staff to patient ratios can be offset by increased fire protection measures.*[306]

Warrington agreed that the engineering solutions being implemented in the upgrade at KRS '*did not require any changes to the staffing levels*'.[307] However, the fire drills demonstrated that residents could be evacuated slowly:

> *with evacuation times being expected to be less than 13.1 minutes in 98% of cases at night with client to staff ratios greater than or equal to 10:1. The fire drills identified problems with uncooperative clients, with communication between staff, with keys and poor lighting most frequently. Staff training and client lists not available were identified less frequently in 10% and 7% of drills respectively.*[308]

The report also contrasted the system in the United Kingdom where the Department of Health Fire Code (England and Wales) provides for a minimum of 1:15 ratios but does not specify automatic

303 Exhibit 283, p. 5.

304 Exhibit 283, p. 7; see also comments on evacuation times in the Dibben Report.

305 Exhibit 283, p. 8.

306 Exhibit 283, p. 12.

307 Exhibit 283, p. 12.

308 Exhibit 283, p. 12; see also the Dibben Report.

sprinkler protection. Furthermore, the system in Northern Ireland (HTM84) requires '*a minimum of four staff on the premises if sub-compartments house up to 9 clients*'.[309]

Finally, the Warrington Report stated that:

> *[w]ith no other changes to the fire safety system at the time of the fire on 8 April 1996, it is considered that staffing levels would need to have been tripled to provide a substantially higher probability of reducing the number of fatalities. The risk reduction would have resulted more from earlier detection at the fire rather than the availability of additional staff to assist with the evacuation. Such an approach is considered to be inefficient when compared to the fire safety update being undertaken at the time of the fire.*[310]

The State of Victoria in its Reply nicely summarised the statement of Mr John Annison, Lecturer, Deakin University. Mr Annison's statement on staffing levels was tendered by the Parents' Association. The summary is as follows:

> *(a) In relation to staff levels, no universal standard exists for staff:client ratios in residential settings at any time of the day.*
>
> *(b) The client/staff ratio in operation at Unit 30/31 on the night of the fire was significantly less than that found in most comparable settings.*
>
> *(c) A figure of 1.75 staff to 25 clients is reasonably indicative of optimum night staff ratios once all clients have gone to bed.*
>
> *(d) Prior to 11.30 pm staffing in the evening hours should have been one staff per flat to ensure adequate supervision and occupation of the clients.*
>
> *(e) The primary consideration in determining appropriate staff levels is the clients' daily living needs, but Mr Annison expected that the fire safety hardware and staff training would enable staff to evacuate clients safely in an emergency.*[311]

The Reply argued that Mr Annison's analysis is 'unhelpful' in a consideration of what was an appropriate night-time staffing level to deal with fire emergency. It pointed to the fact that the analysis *'relates primarily to appropriate staffing levels to supervise and occupy clients'*. It was submitted that the examination of other matters going beyond a suitable level for fire emergency is not the ambit of the inquest. This is agreed. However, given:

(1) an inadequate level of supervision in the area of fire risk behaviour;

(2) that the design and operation of Unit 31 had significantly changed to create difficulties for supervision and fire evacuation; and

(3) that there was an inadequate fire safety system;

the statement of Mr Annison on supervision is relevant. Further, it is supportive of the Warrington Report.

Mr Radler was asked in evidence whether he would have *'considered increasing staff over the the night time period, to deal with that situation by increasing early warning or early awareness of fire?'*. In answer, he replied that *'I would have considered it, but I would have been under a deal of restraint to have done much about it, though'*.[312]

309 Exhibit 283, p. 12.

310 Exhibit 283, p. 12.

311 State of Victoria Submission in Reply, pp. 610-611, para. 1.38; see also Exhibit 258.2.

312 Transcript, p. 6509.

It was also argued by the State of Victoria that '*increased staffing levels to act as an early warning system in the event of a fire emergency situation was and is an inefficient use of resources'*.[313] It presented persuasive cost figures in support.[314]

While additional staff may be an inefficient use of resources in the long-term, in view of the identified risk and inadequate fire safety system, as a short-term solution it was not adequately investigated (if at all). Once it was recognised that interim hardware solutions were not an option, a '*building by building'* approach was still available. When it was decided to move the residents back into Unit 31, and in view of the fact that Building 37 was the largest accommodation centre at KRS, staffing levels for fire emergency and supervision should have been seriously considered. The fact that a report such as the Warrington Report (Staffing Levels for Fire Emergency) was not undertaken is an indication of a lack of adequate attention to this issue. On a cost-benefit basis it was always going to be a short-term solution.

In addition, it was argued that the issue of whether there would have been sufficient funding had not been considered by the inquest. The type of figures disclosed in the State's Reply were arguably readily available to the State of Victoria but were not put until the Reply. Also there were a number of questions relating to funding on this issue, one of which was:

> *Coroner to Ms. McCartin (Disability Services Manager): Do you think funding would have been available for it?*
>
> *Answer: I'm not completely clear that at that stage the – there weren't recommendations for additional staffing out of the Umow Lai report, which was the guiding report as it stood. Had there been a basis for it, then there would be a process at least to seek funds.*[315]

It is recognised that Ms. McCartin was in a difficult position. She had only been Disability Services Manager at KRS for a very short time before the fire. She too did not have that very necessary corporate knowledge of the issues. Accordingly, any implied criticism of her management must be viewed with a degree of caution. Following on Ms. McCartin's answer it was further argued in the Reply:

> *As the answer of Ms McCartin above reflects, ULA did not, in its report or otherwise, recommend an increase in staffing levels either in the interim period to completion of the upgrade or at all. (T.2975-6) The State of Victoria was entitled to and did rely upon ULA to identify interim and final solutions in respect of the upgrade of the fire safety system. As the fire safety consultant did not draw to the attention of the State of Victoria any deficiency in the staffing levels, it was deprived of the opportunity to consider the issue. This failure on the part of ULA was considered in greater detail at pages 130-131 of the earlier submissions lodged by the State of Victoria. At the very least, it is submitted, ULA should have looked at each unit individually to ascertain whether the fire safety system in each unit was satisfactory in the interim period. This would have included an assessment of issues in the context of the hardware in place.*[316]

313 State of Victoria Submission in Reply, p. 599, para. 1.6.

314 State of Victoria Submission in Reply, p. 599, para. 1.4: '*The addition of one extra staff member per flat on the KRS site prior to the upgrade would have required twenty six extra staff at an annual cost of $1,007,200.00. If a further additional staff member was included in the units not converted to flats, the additional cost per annum would have been approximately $1,665,746.00*'.

315 State of Victoria Submission in Reply, p. 599, para. 1.41; Transcript, p. 6887.

316 State of Victoria Submission in Reply, pp. 612-613, para. 1.44.

This submission does not take into account the Lumley and Dibben reports, nor does it take into account the knowledge of senior staff such as Mr Vasan who was concerned about staffing levels and fire emergency in 1993.[317] More importantly, the ULA Report remarks that:

> *limited fire detection and lack of local fire alarm warning within the units means these areas are a potential threat to the clients. Time line analysis for a sleeping area fire indicates that insufficient time will be available for the staff to evacuate the clients, even with earlier detection through the use of smoke detectors.*[318]

This statement alone clearly identifies the night-time risk. In addition, Mr Lai in evidence also indicated that he communicated the fact to KRS that '*the risk in the dormitory and the sleeping area would be significantly higher than in other areas of the site'*.[319]

It is even more concerning when it is discovered that Ms. McCartin was not informed about the significant fire safety issues at KRS. She was responsible for the Direct care management of the residents. Her evidence on this issue is telling:

> *Miss Dixon: See Mr Taylor has given evidence to the inquest that he was aware from 1988 of an enormous risk to clients at Kew caused by the inadequacy of the fire protection system and provided to Kew. Now were those matters that you were briefed about by Mr Taylor?*
>
> *Answer: No.*
>
> *Question: Did you ask him to brief you fully about what the fire protection situation was at Kew, pending the upgrade?*
>
> *Answer: No, I was briefed on how to read the panel prior to the upgrade so that, if necessary, I could act, but not – no – I didn't ask for a full briefing on the state of – – Coroner: Were you briefed on any of the risks?*
>
> *Answer: No.*
>
> *Ms Dixon: Certainly, you had though, didn't you, available to you, the copy of the official fire drill record that has, been tendered just before – didn't have that?*
>
> *Answer: No.*
>
> *Question: But you were, when you took on the role, in charge of fire drills and fire response training and those issues, weren't you?*
>
> *Answer: Yes.*

317 Exhibit 299. See Mr Winn's statement about Vasan who understood that '*there were deficiencies in the quality of procedures and some equipment and documentation, and found him anxious that improvements be made at Kew. Srini Vasan specifically expressed his concerns about staffing levels at night and that this together with their lack of training would provide difficulty in effecting evacuation of residents in an emergency*'. (Winn, para. 11. Referred to in the introduction to this section. See also discussion in the Findings in **Part 2 Knowledge of Risk and System Deficiencies 2.2.3 Consultants' Surveys and Their Use (6) Scope of the 1994 'Audit': The Role of ULA and SSL.)** See also Mr Taylor's evidence in the Transcript, p. 5222:

Answer: Because of the nature of the early – our only basic protection was an early detection system, given our other problems within the – on the site, it was imperative we have this. Because of the buddy system. Because we have our total reliance on the buddy system and contacting the units ourselves with a telephone call, it seemed imperative that we have local reporting – local warning, and as early detection as possible. Given we only had one person on duty at some times, it was obvious I think that people were extremely at risk in case of an emergency.

Coroner: So you are not an expert in fire safety and you have recognised the problem?

Answer: Yes.

318 Exhibit 143 – ULA Report, p. 17.

319 Transcript, p. 3579.

Question: Mr Taylor he has minuted in the executive meeting minutes in 1995, in February, specifically raised the question of whether the fire committee should be reconvened; were you aware of that?

Answer: No.

Question: Did Mr Radler, when he handed over his job to you, tell you anything about any concerns he may have had about any complacency regarding fire issues at Kew?

Answer: No.

Question: Did he tell you anything about fire drills and whether they were up to standard or not, or whether there were problems with fire drills at Kew?

Answer: No, he told me that there was a timetable of drills.

Question: Did he tell you anything about the importance of fire drills?

Answer: No, not – no .

Question: Were you aware of the fact that he had written a letter regarding delays with the fire upgrade project; a letter of complaint, in effect, and concerned about the risk to clients?

Answer: I wasn't aware he had written a letter, but I was aware that when I came on he said that, you know, it is happening and it is due for completion and that he was keen to see that happen but I didn't know that he had written a letter per se, no.

Question: So when he told you that he was keen to see it completed, did you say to him then, well, what is the current situation now; what is our fire protection system here?

Answer: No. I knew what the fire protection system was.

Question: It seems that your knowledge of what the fire protection was extended to knowing that there were some smoke detectors, some heat detectors, and some break glass alarms in the existing system?

Answer: Yes, and the panel system. Yes.[320]

It is in light of this level of communication between management at KRS on the important issue of fire safety that the question of staffing levels at night must be judged.

It was also argued by the State of Victoria in support of the MFB proposition:

> *that if KRS staff and the MFB had been present within five or so minutes of ignition of the fire, they would have been able to rescue the deceased from the fire before they came to much harm. This is consistent with Mr England's opinion (exhibit 283). This is notwithstanding the MFB noting that the KRS evacuation system had several deficiencies (paragraphs 16-18, 120-123). The corollary of this proposition is that neither staff numbers nor evacuation procedures contributed to the cause of death.*[321]

This point ignores both the supervisory aspect[322] and the ability of staff to be an early identifier of fire.[323]

3.13.4 CONCLUSION

It is agreed that the proposed fire safety upgrade, which was nearing completion on the night of the fire, would probably have saved the lives of the nine residents. Further, it is agreed that a properly operating smoke alarm system was likely to have improved the outcome substantially.

320 Transcript, pp. 6868-6870.

321 State of Victoria Submission in Reply, pp. 598-599, para.1.3.

322 Especially in the area of fire risk behaviour.

323 See Exhibit 283 – Warrington Report on Staffing Levels; see also discussion in Transcript, pp. 6884-6885.

Clearly, the fire services upgrade with its engineering solutions, when completed, would have substantially addressed the staffing issue. However, in spite of the warnings in the Lumley, Dibben and ULA reports on the problems associated with low staffing levels at night, the issue was not addressed in the interim.

The residents were accommodated in temporary accommodation during the renovations and were moved back into Unit 31 on 5 November 1995.[324]

Reliance and focus was placed on completion of the upgrade rather than on an appropriate assessment of the staffing levels for the existing system and, in particular, the newly renovated Building 37 (Unit 31). Tracing the warnings of the Lumley, Dibben and ULA reports, there appears to be a clear message on this issue. It needed to be addressed while the upgrade was being completed. It was not. Management was not deprived of the ability to act because of any failing by ULA but by its own failure to take advice.

There is no doubt that KRS management considered 'interim solutions' to be important. Although an additional staff member was rostered at the main administrative block to monitor the fire panel, this was not sufficient to address the staffing issue. The additional member of staff was rostered because of the lack of local alarms in some units and did not provide extra assistance for either management of fire risk or evacuation. Also the 'buddy system', whereby staff from designated adjoining units assisted on notification of alarm, was not formally in operation at the time of the fire. Under the response system that operated on the night, the staff that were called from other units had little or no knowledge of the residents in Building 37 or of the physical layout of the building.[325]

Another alternative – keeping the residents in the temporary accommodation in the very short-term – was apparently not considered.

3.14 FAILURE TO INTRODUCE 'INTERIM' SOLUTIONS

3.14.1 INTRODUCTION: RELEVANCE

Simply put, when an organisation has recognised inadequacies with fire safety systems, it must commence a process to manage that risk. Obviously, the seriousness of the situation at KRS was well recognised by its management, as evidenced by the long and persistent pressure to upgrade the fire safety systems. In that sense management was, for a number of years, attempting to deal with the risk.

Management at KRS was concerned about the interim period pending upgrade. The importance of managing risk was well recognised before advertising for a consultant in 1994. This is also evidenced by an approach to Wormald in 1993 in an attempt to find an 'interim solution' to hardware problems. Further, on 16 December 1993, Mr Taylor wrote to Savona (CMB) following his visit to the site. The letter opened in these terms:

> *Kew Cottages wishes to introduce additional interim protection equipment pending the commissioning of the new system under your project management brief* [and that Kew] *will, in the main, be dependent on your (Savona's) recommendations around the total system.*[326]

324 Transcript, p. 6857 (Ms. McCartin).

325 See MFB Submission, p. 122, para. 214(x).

326 Exhibit 172.

In his evidence, Mr Taylor highlighted the reason for concern about interim solutions:

> *Answer: Because of the nature of the early – our only basic protection was an early detection system, given our other problems within the – on the site, it was imperative we have this. Because of the buddy system. Because we have our total reliance on the buddy system and contacting the units ourselves with a telephone call, it seemed imperative that we have local reporting – local warning, and as early detection as possible. Given we only had one person on duty at some times, it was obvious I think that people were extremely at risk in case of an emergency.*
>
> *Coroner: So you are not an expert in fire safety and you have recognised the problem?*
>
> *Answer: Yes.*[327]

Mr Taylor gave evidence that he had been led in this direction because MFB officers attending false alarm calls were the first to advise staff in the unit that the 'false alarm' was possibly a fire.[328] But history also shows that he was involved during most of 1993 in investigating the local alarm issue.[329]

The interview panel for the consultancy comprised Messrs Savona, Taylor and Vasan. During the interview, 'interim solutions' formed a significant part of the focus of the panel's questions. The pressing need for an interim solution pending upgrade was squarely put by Counsel for the MFB during the inquest when he said (in part):

> *If ever there was a situation over a period of years, it seems to me that, on behalf of the Fire Brigade, that needed to be addressed by way of interim measure, then it was this one. Yet the system failed to produce any measure when the evidence discloses at least some deserved serious consideration.*[330]

This quotation is also used by the State of Victoria in support of its arguments on the importance of interim solutions.[331]

Some of the submissions place great store on the failure to provide advice on a suitable interim hardware solution. In reality, the balance is more complex than that. There were other factors involved, which ranged from the breadth of the original request, focus on a 'technical (engineering) solution' using technical people, budgetary constraints, the need to urgently complete an upgrade and the developed industry knowledge on 'interim solutions' during this period. It was well recognised that the previous 'ad hoc' approach to the fitment of fire safety hardware was unsatisfactory. This being the case, a focus on an integrated upgrade of the fire safety services was not only appropriate: it was essential and overdue. Clearly, as a fully integrated technical solution was necessary, it required resources and project management. It could not be done overnight.

The SSL Submission is supportive of this view (and said in part):

> *The advice in the ULA report is that what is required at Kew was the wholesale approach which was recommended by Steeves Lumley and Dibben. All experts in the industry were ad idem. This is probably so in our submission because of what Cooper said @ 5644: that there is no developed body of knowledge about interim protection equipment.*

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327 Transcript, p. 5222; see also Exhibit 229 – Mr Winn's evidence about Vasan.

328 See Transcript, p. 5412; Exhibit 172; State of Victoria's Submission, p. 51, para. 10.4.

329 See discussion in **3.14.2 Early Moves towards a Local Warning Device: Wormald's Quotation.**

330 Transcript, pp. 5811-5812. NOTE: It is necessary to read this quotation in its context to see another significant issue. See complete quotation in **3.14.4 Management's Role: A Risk Management Approach.**

331 State of Victoria Submissions, p. 50, para. 10.1.

There was nothing new in this, even in the minds of those managing Kew. Vasan said (at 5997-8) that he knew there was an urgent need for an upgrade by the end of 1993 and appreciated that what was needed was not the ad hoc additions that had been done before, but a complete upgrade.[332]

3.14.2 EARLY MOVES TOWARDS A LOCAL WARNING DEVICE: WORMALD'S QUOTATION

The lack of local alarms in many residential units at KRS was of concern to management. In this regard, in early 1993, discussions occurred between Messrs Taylor, Savona and Knight about the installation of local alarms in a number of units not covered by this system. After those discussions, Mr Knight contacted Mr Howie (Wormald) about this proposal. On 22 March 1993 Wormald quoted Taylor for the:

[s]upply and installation of an alarm bell in each of units.....30/31. Note double units shall have one bell.

The alarm bells shall operate on a unit by unit basis.

Operation of the bells shall be via a sensor device connected to the detector circuits, ... on operation of a detector the sensor device shall switch a local 12 volt D/C supply to operate the relevant alarm bell. The 12 volt D/C supply provided in our quotation does not have battery back-up.

The sensor devices are not an approved device and it is our understanding that dispensation has (not) been given by the fire brigade for their use.

The sensor device is one of a special designed to overcome the special circumstances in this case, we will therefore require lead time to provide these units.[333]

Installation cost was $8629. Basically, the system was not proceeded with as it was not a recognised and approved system. Mr Taylor considered the system unsatisfactory as Wormald would not back the system because it was not approved.[334]

The Wormald quotation was forwarded to Mr Knight who sent a copy of it to Mr Taylor with a note, which indicated that the measure was temporary and was '*not in accordance with the regulations'*, and that as the MFB would not accept the recommendation, it must be presented to the Building Referees for approval.[335] Mr Taylor did not recall the letter, but acknowledged that it may have been received.[336]

Wormald advised KRS that the system was not approved.[337] Mr Howie considered that, if it were approved, Wormald would have no problem with the system. Wormald contacted the MFB which indicated that the system was not approved. Apparently, dispensation could still be sought by KRS.[338] Both Knight and Howie believed that the MFB could grant dispensation.[339]

332 SSL Submission, p. 28.

333 Exhibit 176 – Mr Vasan's statement (SV6).

334 Transcript, p. 5202.

335 Exhibit 212 – Mr Knight's statement, para. 2.3.

336 Transcript, p. 5205.

337 Transcript, p. 4799.

338 Transcript, p. 4801.

339 Transcript, p. 5201.

During the inquest counsel for the MFB advised that it was not an 'approving authority'.[340] However, a letter sent to Mr Taylor from the MFB Board in 1989 tends to indicate that the MFB did give dispensations. Mr Parsons (MFB Board) considered giving dispensation to some aspects of the cabling used between the sub-fire indicator board and the main fire indicator panel on condition that a plan to upgrade the entire site to Australian Standards and MFB requirements was implemented without delay.[341]

The Submission by Villamanta Legal Service suggested that:

> *[t]his letter indicates that Mr Taylor was familiar with obtaining dispensation as he had previously requested it. When this matter was raised with Mr Taylor an objection intervened and the question was lost (5461).*
>
> *Mr Taylor knew that Mr Knight had some connection with Building Referees, that he was on the Board, and "probably look at an interim arrangements that we were suggesting to him" (5474). So that avenue was available to him.*
>
> *Yet no approach was made to the Building Referees Board to see if the system could be approved (5460). Mr Taylor explains that it was not pursued because Capital Management were now on site and "we had pushed our boat out in their direction" (5460).*
>
> *Mr Taylor's assertion does not seem correct. Mr Savona, from Capital Management, does not become actively involved again until November 1993 (Statement of Emmanuel Savona, para 12). This is eight months later.*[342]

The significant point is that Mr Taylor was aware of some of the difficulties surrounding interim hardware solutions prior to the discussions with ULA/SSL the following year. Dibben was involved in an audit in early 1993. However, Mr Taylor did not recall having discussed the issue with the fire experts, although Taylor believes that he must have.[343]

In late 1993 Mr Vasan obtained additional quotations for local alarms. One was from FFE on 9 December for $27 000. The second, from Jonkar on 13 December, was for $29 680, and the third from Wormald dated 23 December was $12 529 (with battery backup).[344]

Villamanta Legal Service submitted that:

> *every effort should have been undertaken to seek approval of or dispensation for the system. This was not done and a local alarm was not installed in Unit 30/31. Seeking approval or dispensation was within the capabilities and experience of Kew management.*[345]

Mr Taylor was concerned that the MFB may arrive at a unit in response to an alarm of which the unit's staff were not aware.[346] He was also concerned that if an alarm activated, the unit had to be advised by administration.[347] Ms. Denise Harrison, Manager, Residential Care, was advised of the problem. A member of staff was appointed during the night to monitor the fire indicator panel. Also mobile phones were provided for the AHCOT team so they could be contacted in the case of an emergency.[348] These measures were still in operation on 8 April 1996.

340 Transcript, p. 4799.

341 Exhibit 159 – Statement of Mr Taylor (JT11) (letter dated 3 August 1989).

342 Villamanta Legal Service Submission, pp. 19-20, para. 6.3.3.1.

343 Transcript, p. 5403.

344 Exhibit 176 – Statement of Mr Vasan (SV8 and SV9).

345 Villamanta Legal Service Submission, p. 20, para. 6.3.3.1.

346 Transcript, p. 5199.

347 Transcript, p. 5202.

348 Transcript, p. 5202.

In November 1993, Messrs Savona and Taylor discussed the need for a brief description from Taylor of what was required from a new fire system.[349] Taylor replied by letter on 16 December 1993, which noted:

> *Only seven of the residential buildings have mimic panels installed in them. The remaining fourteen are reliant on either the arrival of the fire brigade or on phoned through advice from either the switchboard or the unit manager of unit 7/8 where the control panels are located.*
>
> *A new system should provide:*
>
> *Local mimic panels including warning alarms (bells in each building.).*[350]

Mr Savona, in his statement, indicated that Taylor requested that the issue of local sounding alarm bells be included as part of the consultancy. This was undertaken. If the local alarms were to be installed it was to be funded *'from the KRS annual provisions and that such money was already available for this purpose'*.[351]

3.14.3 ULA AND SSL'S ADVICE: A 'HARDWARE SOLUTION'

(1) SCOPE OF THE 1994 PROPOSALS FOR AN 'INTERIM' SOLUTION

The interviews for the consultancy provide a useful starting point for the examination of the question of the scope of the interim proposals. Both during and after the interview one of the principals of the successful applicant, Mr Lai, was very aware of Taylor's concern about having an interim solution by way of local alarm. The issue was raised at PCG meetings. One statement that can be made about the request by KRS of ULA for interim hardware solutions is that it was not a 'casual inquiry'. It should also be noted that in responses to the interview on behalf of one expert consultant's firm (Mr Knight), it was said: *'Forget interim. Go for final solution'*.[352]

The interviews provide one of the keys for what was intended by way of interim solutions to the fire safety problem. A summary of the interview assessment with Lai (ULA) and Johnson (SSL) on 10 March 1994 is nicely put in the State of Victoria's Submission:

> *[T]hey were asked the following – "1.4 What interim solution would you recommend for our situation where a number of buildings do not have local warning alarms?"*
>
> *The panel have recorded the response of ULA/SSL as:*
>
> *"Will provide interim alarm system, very logical system." (Mr Savona's assessment sheet)*
>
> *"Low cost interim solution will be provided." (Mr Vasan's assessment sheet)*
>
> *"Logical analysis – to complement final solutions." (Mr Taylor's assessment sheet).*[353]

At the inquest Mr Lai explained his understanding of the questioning when he stated that.

> *[m]y recollection is that we need a means of raising a local alarm at the unit – some means of getting the communication to other units and to be addressed as an interim measure until the upgrade.*[354]

349 Exhibit 214 – Statement of Mr Savona, para. 12.

350 Exhibit 159 – Statement of John Taylor (JT24).

351 Exhibit 214 – Statement of Mr Savona, para. 13.

352 Exhibit 242.

353 State of Victoria Submission, p. 52.

354 Transcript, p. 3388.

Without doubt ULA viewed the responsibility to advise on a local alarm-type solution as being part of its contractual arrangement:

> *Mr Redlich: In the course of your evidence, you have repeatedly said, and you repeated again today in response to Mr Bell's invitation, that the only requirement or request ever made by the Department about interim measures, was one relating to local alarms? Isn't that so?*
>
> *Answer: Yes.*
>
> *Question: So that every other interim suggestion that you might have made during the course of your working with Kew, from the time of your interview until the completion of your audit, was then something that you merely volunteered, but that you regarded as not being part of your contractual obligations; is that the position?*
>
> *Answer: In a strictly contractual sense. Yes.*[355]

On the issue of low cost, it was stated:

> *Answer: To my recollection one of the items requested to look at was low cost alarm solutions for buildings.*
>
> *Question: Did you agree with the Department to do so?*
>
> *Answer: Yes we did. ...*
>
> *Question: It was a contractual obligation as between you and the Department was it, that you provide that advice?*
>
> *Answer: Yes, that we provided an investigation (indistinct).*[356]

The State of Victoria in its Submission urged the view that '*the questions were fairly clear and the scope of the task sufficiently broad to enable the consultants to consider all interim solutions that might be available'*.[357] In turn it appears to argue that the arrangement between ULA and SSL was that:

> *SSL submitted a scope of work quote to ULA (Exhibit 252) including "detailed analysis of site wide fire alarm systems and specific short and)long term recommendations." ULA accepted the quotation to carry out a fire safety audit "in conjunction" with ULA. (Exhibit 252).*[358]

The result was that SSL was under a contractual duty to ULA '*to provide specific short term recommendations that were appropriate'*.[359] Therefore there was a duty of care owed by SSL and ULA to KRS:

> *We have previously referred to the duty of care owed by both ULA and SSL to KRS and the occupants of the KRS complex.*[360]

If this submission reflects the understanding of the breadth of the original brief, what occurred between ULA and SSL may be important. SSL was at an early tender interview. Also the correspondence between SSL and ULA may provide clues towards the understanding of the parties

355 Transcript, p. 3489.

356 State of Victoria's Submissions, p. 54, para. 10.12 (Mr Lai's evidence) (emphasis added).

357 State of Victoria's Submission, p. 53, para. 10.9, in support adopts the 'Coroner's view of the questions that were asked of the interviewees' (referring to discussion between Counsel and Coroner at Transcript, p. 5807).

358 State of Victoria's Submission, p. 54, para. 10.11 (see also next quote).

359 State of Victoria's Submission, p. 54, para. 10.11 (see also previous and next quote).

360 State of Victoria's Submission, p. 54, para. 10.11 (see also previous quote).

on interim solutions. However, KRS's notes of the interview and Lai's understanding do not broadly extend the job on interim technical solutions. It is also clear from the interview notes that any interim system was to be low cost and to complement final solutions. However, Mr Lai made notes on an agenda for a later meeting between ULA and SSL *'build in interim solutions ... Discuss the possibility of different solutions for different buildings'*.[361] The note is arrowed to topic 3: '*Discuss immediate work regarding inter-unit communication (raised during interview)'*. An additional note (to topic 3) states ' *unit alarm'*. The notes are indicative of the concern for interim measures.

The ULA Submission in Reply pointed to the fact that *'no requirement for the consideration of interim measures is contained in the fire safety consultant's brief and no request was ever made by letter or in writing to this effect'*,[362] and quoted the following evidence in support:

> *Question: If the issue of interim measures was to be included as something to be considered by the project implementation consultant against that background of material would you have expected it to receive special mention in the consultant's brief?*
>
> *Answer: Yes, I would.*
>
> *Question: Would you have expected it to receive special mention in the project – in the tender interview?*
>
> *Answer: Yes, it would.*
>
> *Question: Would you have expected it to receive special mention in the contract?*
>
> *Answer: Yes, it would.*[363]

The issue was discussed in the tender interview, and accordingly, it would be reasonable to expect that those discussions, as far as they went, formed part of the contractual arrangement. Also the ULA Submission tended to confirm this view:

> *On 10th March 1994, during the interview for the fire safety upgrade works consultancy attended by Peter Johnson and Dominic Lai, John Taylor raised the possibility of installing local alarms in buildings without fire bells. Peter Johnson responded stating that SSL's Russell Cooper had specialist expertise in this area and could be asked to look at this matter.*[364]

In addition, any management of interim hardware solutions needed to consider integration into the final product. This was recognised in one of the answers recorded by Taylor at the initial interviews for the consultancy: *'Logical analysis – to complement final solutions'*. Budgetary issues were also a consideration: *'Low cost interim solution will be provided'*. The '*Interview Report*' for the consultancy not only indicated that the panel[365] were impressed with Mr Lai's demonstrated '*keen awareness of the current fire protection systems at Kew'* but also with the fact that the group presented a team approach and emphasised resident awareness, development of a range of building options and '*pursuing sound engineering solutions to design problems and managing to tight time and budgetary constraints'*.[366] 'Tight' budgetary constraints were obviously a consideration.

The importance of budgetary concerns can also be objectively measured by restrictions placed on the project itself. For example, in 1994 ULA recommended re-wiring of the alarm system. By the time of the upgrade, a different approach was being taken. At a 'post tender' meeting on 17 July

361 Exhibit 169 – Meeting 3 May 1994, p. 154.

362 ULA Submission in Reply, p. 24, para. 4.23.

363 Transcript, p. 3457.

364 ULA Submission, pp. 20-21, para. 3.8.

365 Messrs Savona, Taylor and Vasan.

366 Exhibit 237.

1995, '*areas where the cost of the project could be reduced'* were being discussed between KRS management, ULA, BSA and Wormald. Following this meeting it was decided to re-use existing wiring and reduce costs in a number of areas.[367] This is confirmed in the statement of Mr William Mitchell of BSA. Mitchell was also concerned to contain the cost due to asbestos. He said:

> *It was also clear, after the receipt of tenders, that the tender prices were far in excess of the budget that had been granted pursuant to the ULA recommendations. ULA were thereto were requested by Mr Bentivoglio to redraw the technical specifications and modify the scope of the work so that the tenderers could be requested to provide a price on the revised scope of works that was within budget. I further negotiated with WFS concerning their price for the revised scope of works and, as part of these negotiations, I discussed the asbestos issue and its management.*[368]

ULA was also required to cost both a full and partial sprinklering system. It was elected to proceed with the latter.

Mr Mitchell's Department was approached by Mr Savona (CMB) to act as Project Co-Ordinator because '*due to a lack of resources at KRS, it was determined that KRS would not be able to act in the role of Project Co-Ordinator'*.[369] It has not been determined whether this refers to human or financial resources.

It must be remembered that, during the work on the upgrade, Victoria was in the midst of a difficult financial period. Following some prompting from the bench Mr Taylor indicated that '*the bureaucracy can be a very frustrating place in terms of pursuit of capital works, particularly in this period of time when – when capital works basically dried up and there was none for many – many number of years.*[370]

The State of Victoria submitted that '*there is no evidence that budgetary or other constraints contributed to ULA or SSL's failure to recommend interim solutions'*.[371] This submission has been considered.

It is difficult to accept that the original brief to provide 'interim' solutions was wide-ranging. The initial question in the tender interview set the tone: it focussed on hardware issues – local, low cost and able to be integrated. It is noted that KRS's earlier inquiries to Wormald also sought out a 'local alarm'-type solution. From that inquiry it appears that an additional and appropriate restriction was that any solution was approved. That earlier foray into the area of interim hardware solutions also indicates that the main players at KRS/CMB[372] were not new to the issues involved.

The evidence establishes therefore that any interim solution at KRS concerned buildings where there were no local alarms and that it should be low cost and must complement the final solution. As there was no Departmental contract, documentation indicating the intention surrounding the interim hardware solution the interviews and other material indicates the position.

While it could be said that the involvement of SSL expanded the potential for broader advice, the original understanding (on technical solutions) effectively operated to limit the extent of available solutions. Certainly, more complex (and expensive) technical solutions were discussed. This indicates an appropriate degree of professional concern for fire safety at the KRS site. It must be

367 See Exhibit 211 – Mr K. Howie's (Wormald) statement.

368 Exhibit 258, p. 4, paras. 11-12.

369 See Exhibit 258 – Mr Mitchell's statement, pp. 1-2, para. 5.

370 Transcript, p. 5251.

371 State of Victoria Submission in Reply, pp. 377-378, para. 3.12.

372 Messrs Taylor, Vasan and Savona.

remembered that the ULA 'audit' also provided a vehicle to look at other 'interim' management-type solutions. While Mr Lai has recognised some limitations with ULA's original audit, he commented on the fact that he would have expected the issue of 'interim measures' to receive special mention in the consultant's brief and in the contract.[373] Lai also acknowledged:

> *Question: ... [L]ooking back on this if you had your time again, that you'd do more – you'd look more closely at maintenance and the present condition or the condition that existed in the buildings at the time; am I correct i(n) my understanding?*
>
> *Answer: If I were commissioned to do that detailed fire safety audit survey, yes, I would.*
>
> *Coroner: Does this sort of process focus your mind – we're talking about the inquest – focus your mind on your systems?*
>
> *Answer: ... [T]o be positive about the whole thing, I think I will walk out from this process a much better fire engineer.*
>
> *Question: The trouble is we can't put all fire engineers through this process?*
>
> *Answer: You may not have any left.*[374]

Many management issues are raised for consideration in the ULA audit. There was advice in the audit that was not taken. Also those representatives of KRS and CMB who received the advice on the interim hardware solutions (when taken together) had considerable corporate knowledge of the KRS operation (and fire risks), Fire Brigade Reports and the Lumley, Dibben and ULA reports. Knowledge of the Fabric Survey was presumably also with KRS management.

There was a significant paucity of communication on fire safety issues between the two important areas of management at KRS: Mr Taylor's area and Disability Services run by Ms. McCartin. This is in stark contrast to the creditable communication over essentially the same issue between Taylor and Harrison in 1993.

For management to say now that KRS did not act on other interim solutions because it was not adequately advised is difficult to accept.

(2) TYPES OF INTERIM HARDWARE SOLUTIONS AVAILABLE

The options considered by ULA and SSL representatives were local alarms (of the type already installed in some units at KRS) and

- low energy sounders directly wired into the existing detector circuit; or
- interconnected stand-alone smoke alarms.

As a result of the earlier arrangements between Messrs Savona and Taylor, interim measures were to be financed through KRS's budget allocation.

Shortly after ULA was appointed the consultant for the audit in April 1994, a meeting was held between the consultants and the Department. ULA was represented by Mr Lai and David Ulhorn, and SSL by Russell Cooper and David Johnson.[375] The Department was represented by Messrs Savona, Taylor and Vasan. Interim measures were discussed. Mr Vasan stated that the quotations obtained in late 1993 were discussed at that meeting.[376] However, Mr Lai does not believe that the quotations were discussed.[377] The Parent's Association took the view that '*[t]he question whether*

373 Transcript, p. 3457.

374 Transcript, p. 3308.

375 Transcript, p. 3398.

376 Exhibit 176 – Statement of Mr Vasan, para. 9.

377 Transcript, pp. 3264, 3419.

or not ULA were provided with the quotations from Wormalds and FFE for the installation of local alarm panels which had been obtained by Vasan and Taylor was of no great consequence. ULA had the responsibility for using their expertise to identify a solution'.[378]

A meeting took place between ULA and SSL on 3 May 1994. One item on the agenda was '*Discuss immediate work regarding inter-unit communication*'. Mr Lai noted '*build in interim solutions*'.[379] The desirability of providing inter-unit communication was raised in connection with an interim solution. Mr Russell Cooper (SSL) met with Lai at Johnson's suggestion to '*provide technical advice ... in relation to such interim measures'*.[380] As a result of the meeting Mr Cooper came up with suggested options which were low cost but not designed to be integrated into the final solution. They were:

- low energy sounders directly wired into the existing detector circuit; or
- interconnected stand alone smoke alarms.

Mr Cooper eventually decided against these two options for a variety of reasons. The 'low energy sounder' was rejected because in its quiescent state it would continuously emit a low level sound, its alarm state would not be sufficiently loud to alert the carers and connection of the device might have interfered with the correct functioning of the circuit to which it would be connected.[381] The 'interconnected stand alone smoke alarms' were rejected on three grounds. The first was *'the loud noises created by these types of alarms would cause confusion and distress amongst clients'*; the second was that they have a propensity to falsely alarm; and the third that they are designed *'more for the personal protection of those with all their faculties in a domestic environment who can react independently to the alarms'*.[382] There is some uncertainty about where Cooper obtained his view that the loud noises would distress residents. In addition the upgrade provides an alarm bell in the units.

In evidence Mr Cooper commented that there is a propensity for this type of system to false alarm. Thus where there were numerous false alarms people fiddle with the system to disable it.[383] The other disadvantage is that under this system the MFB is not notified. On the hearing of the alarms staff would have to break a glass alarm to seek help from outside the unit.[384]

Mr Cooper met Vasan on site to discuss the interim solution problem. His evidence on this meeting is as follows:

> *We really discussed, because the request as it was relayed to me by Mr Lai was that they had this particular problem; they wanted – they weren't just to look at a local (indistinct) solution. He recommended, or Mr Johnson recommended – I can't remember which – that I go out on site and see for myself exactly what it was that they were trying to achieve. I went to the site and had a meeting with Mr Vasan where we had a look at the fire indicator panel and he explained the problem and that was the basis on which I then framed my response.*
>
> *Question: What did he tell you was the problem at that meeting?*
>
> *Answer: That they had a number of – a number of the units had local alarm panels fitted which gave a warning as well as calling the Fire Brigade in – within the unit and that the*

378 Parents' Association Submission, p. 130, para. 371.

379 Exhibit 169, p. 157.

380 Transcript, p. 5752.

381 Exhibit 249 – Mr Cooper's statement, p. 2, para. 4(a).

382 Exhibit 249 – Mr Cooper's statement, p. 3, para. 4(b).

383 Transcript, p. 5603.

384 Transcript, p. 5604.

majority of units did not have this, and that they were seeking to provide that warning in the individual units. He also said that they had gone some way down the track – I can't remember whether he said they, actually, had quotes, or were seeking quotes, for such an upgrade for those remaining units.[385]

This evidence indicates consideration of a broader approach to the interim problems at KRS. Further, it shows that Mr Cooper was aware of the 1993 quotations obtained by Vasan.[386] However, evidently he was not aware of their content. He understood that Vasan was pursuing these quotations with a *'more formal solution, or a more structured engineering solution'* in mind. Mr Cooper was looking for a solution a bit '*off-beat'* or '*off the track'*.[387]

The Villamanta Legal Service Submission nicely put that the dilemma faced by Mr Cooper:

is to produce an interim solution which has only a hardware element rather than being a package of measures both technical and non-technical. The single hardware solution which Mr Cooper was asked to design belonged to a context. The hardware solution would only be partial and would have negative side-effects. In order to accommodate the negative side effects other actors needed to be involved.[388]

Another option was considered by Mr Lai, which was the replacement of thermal detectors with conventional smoke detectors and the installation of local alarm panels in the units lacking local warning. He estimated this option at over $200 000 ($70 000 if smoke detector installation was limited to bedrooms). This option would need to be integrated into the final upgrade because of the high level of redundant cost.

Perhaps the fitting of conventional smoke detectors (with local alarms) was achievable if the final solution was based on the main fire indicator panel addressing the unit sub-panels. This type of solution meant that detectors on the sub-panels would be conventional and on a number of zones. The fire indicator panels would indicate which zone was in alarm, but not which detector. It would not have a detector specific addressability of the new system.

In evidence Mr Lai agreed that Cooper was considering the options on behalf of the consulting team. In evidence he said:

Question: ... [T]he advice was ultimately given to Mr Vasan and Mr Taylor that there was no such option that could be recommended; is that right?

Answer: I believe the outcome of our recommendation is that we cannot identify a low cost interim alarm solution that could be integrated with the final solution.

Question: Yes?

Answer: That to meet the criteria of that requirement would imply implementing part of the final proposed solutions.

Question: When was that advice given to Kew Cottages – and I mean, it would have been to Mr Vasan and Mr Taylor that the advice was given?

Answer: I believe that was presented at a project control group meeting.

Question: Yes?

Answer: I cannot recall exactly whether – when it was June or July, of 1994.

385 Transcript, p. 5626.

386 Transcript, pp. 5635, 5660.

387 Transcript, p. 5660.

388 Villamanta Legal Service Submission, p. 28, para. 6.5.1.2.

Question: Is there any file note recording the giving of that advice, Mr Lai?

Answer: I don't believe so.

Question: No writing at all supporting – well, not supporting but recording the giving of that advice?

Answer: No, I don't believe so.

Question: Was any report prepared to your knowledge on the question – I mean, written report?

Answer: No, I believe options that were tabled for consideration were mainly presented in verbal form.

Question: So the options were presented in verbal form only?

Answer: Yes.[389]

Both low and high cost interim solutions were considered by ULA. Integratable and non-integratable solutions were aired. The issue of an interim solution was still being considered in June or July. By that time the results of the survey were known to both SSL and ULA. Mr Cooper's advice to ULA that there were no suitable interim hardware solutions resulted in the report by ULA that the upgrade be installed in work packages progressively upgrading safety with each package.

The Parents' Association and the MFB in their submissions pointed to Inspector Martin's interim interconnected package of smoke detectors, local waring panels and alarm sounders which was developed during the running of the inquest as a solution to the interim problem facing KRS. The 'Martin' package would have been subject to the same approval problems as Wormald's 1993 solution. In addition there is a recognised difficulty, from a safety perspective, of following untried and untested solutions. This problem is alluded to in the Parents' Association Submission when it said of the 'Martin' design:

> *combination of interconnected domestic smoke detectors. Evidence was given that such a system was in operation in one of the units at KRS prior to the fire. Although the ULA Report sought to warn against ad hoc smoke detection measures including the use of residential (domestic) detectors, nevertheless there is a compelling argument that such a system would certainly have been better than nothing and would have provided more protection to the clients in Unit 30/31 than they ultimately were afforded.*[390]

At the risk of being viewed as critical of the 'Martin' solution (which is not the case), it is found that it needs to be tested and seriously considered in light of what has been learnt in this inquest. To use this solution as an example of a viable alternative for KRS in 1993/94 does not take account of all the competing factors involved at that time. Use by the industry of 'interim' solutions in fire safety audits at that time is but one of the issues.

Mr Lai alluded to the issue of 'interim' solutions and the fire protection industry in the following passage:

Answer: I cannot recall ever seeing MFB reports on existing buildings that address the matter of interim measures. ...

Answer: No. My answer would be if you take the industry practice as a guide to what is – – what constitutes a fire safety audit then the specific recommendations on interim – specific recommendation on interim measures are not generally considered to be part of a fire safety audit. ...

389 Transcript, p. 3400 (emphasis added).

390 Parents' Association Submission, pp. 129-130, para. 371.

Mr Bell: Yes. I understand you to be saying that if interim measures are to be included as a matter of particular concern that you would expect particular reference to be made to them in the consultant's brief?

Answer: On balance, yes, l would agree with that.[391]

In its Submission, ULA pointed to some of the complexities. Any system would need to have been approved (as for Wormald in 1993):

and any program of works would have required both approval for the work to be done and for the expenditure. Thus the issue of interim measures must be considered in the light of fire safety system approvals and industry practices in 1994, as well as the then available approval processes for works by government, the time delays involved in procuring approval of any new system and the financial and timetable constraints of the works budget.[392]

The MFB submitted that:

ULA/SSL should at least have recommended the installation of local alarms of the kind proposed by Wormald (see Exhibit 174) or Inspector Martin (see Exhibit 166). Mr Cooper's examination of the local alarm option (Exhibit 249 at 3) was inadequate. He rejected this option upon the basis that "loud noises such as those created by these types of alarms would cause confusion and distress among clients in the unit" (Exhibit 249 at 3) when, in fact, this was no basis for the rejection of this option (see the evidence of Mr Taylor at T5800). Mr Cooper's evidence showed that he acted upon an "impression" gained during conversations (T5595) possibly at another job concerning KRS (T5612) though not with MrTaylor or Mr Vasan (T5629). He did not discuss the issue of loud noises with Mr Taylor ((T5630) and gave him no opportunity to correct the false impression (T5530; see also Mr Taylor's evidence to the same effect at (T5800) and Mr Cooper's further cross-examination at (T5632ff).[393]

The Parents' Association stressed the broader issue that:

[w]hen ULA were briefed with the consultant's brief and prepared their audit survey, it must have been patently obvious to ULA that a fire in a residential building at night could result in a major tragedy. The sleeping areas were, in effect, death traps. This knowledge, combined with the knowledge of the extreme vulnerability of the clients at KRS, should have ensured that ULA gave priority upon accepting the tender for designing the fire system at KRS to ensuring that the upgrade was commenced without delay.[394]

In evidence Mr Lai agreed about the risk in the sleeping areas. It had been pointed out in his report. Management had been advised. However, the responsibility for control of the time frames essentially rested with management.

The Parents' Association argued that:

[t]hough the interview process and through the results of surveys ULA was aware of the absence of local alarms in many residential units, the dependence of the after-hours team on the telephone system to alert units affected and buddy units, and the critical lack of

391 Transcript, pp. 3440-3441.

392 ULA Submission, p. 23, para. 3.18.

393 MFB Submission, p. 101, para. 179.

394 Parents' Association Submission, p. 128, para. 368.

sufficient spread of smoke detectors within residential units. Obviously the absence of sprinklers was also a concern but the first priority should have been to addressing smoke detection and local alarms.[395]

The Submission suggested *'a solution which preferably would not result in enormous redundant expense but which could be installed immediately'*. It relied on Mr Cooper's evidence for a solution which met the requirements. The solution proposed:

was to immediately install local alarm panels in the deficient buildings whilst simultaneously installing sufficient conventional smoke detectors in those units to bring them up to a satisfactory standard. Although the conventional smoke detectors would not have had the feature of addressability available under the system subsequently installed by Wormalds, this problem could have been reduced by greater zone separation within the installed fire panels. Subsequently, when Wormalds installed its new addressable fire panel there would have been no impediment to addressable detectors being installed in other areas at KRS. The newly installed addressable fire panel could then address the local panels which had been installed in buildings with conventional smoke detectors. There would thus have been no redundant expense and an immediate solution to the extreme risk confronting KRS.[396]

It is suggested that the mixture of old and new technology should have been adopted in the interim. Mr Cooper gave evidence in support of this option. The Parents' Association argued further that:

[t]he Audit Report was clearly deficient in failing to recommend an effective interim response to minimise risk in circumstances where it had been identified that untenable conditions could develop in sleeping areas before safe evacuation could be achieved. Had such an approach been adopted at KRS it is likely that by 8th April 1996 Unit 30/31 would have been serviced by a local fire alarm panel within the unit and sufficient conventional smoke detectors in bedrooms in Unit 30/31 to create appropriate early warning of fire. The only rider to this hypothesis is the possibility that, if Jonkar were nevertheless employed to maintain such a system, the effectiveness of such a system may have been compromised.[397]

The Parents' Association opined that Mr Lai did not give either a satisfactory explanation for why Mr Cooper's solution could not have been implemented or why it was not possible for ULA and SSL to identify an interim solution to the local alarm problem. As indicated this issue is more complex: there are numerous competing problems ranging from early discussions indicating cost limitations to the state of knowledge within the industry on interim solutions. The knowledge of management at KRS/CMB of earlier interim solutions and cost must also be a factor. Mr Lai's estimate of the cost of the 'Cooper' option must raise questions as to whether it would have been considered in light of an imminent upgrade and the original 'brief'.

The MFB made the point that 21 months expired between the discussion and rejection of interim hardware solutions and the fire, and also that the existing system, if correctly operating, would have saved the lives of the residents. It said:

In the light of the Department's acceptance of the advice not to introduce any interim hardware measures pending the completion of the upgrade it was incumbent upon the Department during this period to take whatever steps were necessary to secure the safety of the residents. The necessary steps were, for example: appropriate management decisions

395 Parents' Association Submission, p. 128, para. 369.

396 Parents' Association Submission, pp. 128-129, para. 369.

397 Parents' Association Submission, p. 129, para. 370.

relating to staff numbers (especially at night); effective management of clients with firelighting behaviour problems; properly conducted, monitored and recorded evacuation drills; reactivation of the KRS Fire Committee etc. No sufficient such steps were ever taken. The ULA/SSL failure to give adequate advice as to the interim measures matter did not alter the primary responsibility of the Department to take care or the consequences of its failure to do so.[398]

While there are limited conflicts in the evidence between what was understood, with little Departmental and consultant documentation, it is not unexpected that there be conflicts. What remains is the impression that interim hardware solutions were under serious consideration by ULA and its subcontracted consultant, SSL. On balance the advice given could not be said to be inappropriate considering:

- the understanding of a cost and integration limitation placed on the brief (because of the imminent upgrade);
- the state of knowledge of 'interim' hardware solutions within the fire protection industry; and
- the need to have a device approved.

There is no doubt that more expensive solutions were being aired. As a result of earlier inquiries during most of 1993, KRS/CMB were aware of cheaper solutions. Management had the necessary resources to deal with the required budgetary issues for both the inexpensive and the more costly options. Whether, in light of an imminent upgrade, sufficient funds would have been made available for the latter is a moot point. However, they did not choose that path.

The significance of 'interim' hardware solutions has been well tested during this inquest. There was no established body of knowledge within the industry at the time of KRS's inquiries. There were appropriate restrictions on the use of untested and unapproved hardware solutions. As a result of the fire at KRS, the limitations on introducing low cost and/or integratable 'interim' solutions in the course of an upgrade have been examined.[399]

In the future the fire protection industry may need to develop suitable practices and procedures dealing with introducing interim systems that may not be as reliable as the final upgrade, but will assist in reducing the overall risk in the short term. Fast-tracking and simplified approval processes balancing the need for safety may well be necessary.

(3) CONCLUSION

In considering the 'interim' solutions, the parties and the experts were focused on hardware issues. The discussions operated to limit the vision to low cost integratable hardware solutions. Once it was decided that there was no suitable interim hardware solution, the concentration moved to completing the upgrade.

It is to the credit of both DHS and KRS management that there was an insistence on examining the issue of 'interim' hardware solutions.

3.14.4 MANAGEMENT'S ROLE: A RISK MANAGEMENT APPROACH

As indicated, management at KRS, by attempting to find interim solutions to the fire safety problem, took a positive step towards reducing the risk to residents and staff. Unfortunately, that very

398 MFB Submission, p. 102, para. 179.

399 See ULA Submission, p. 23, para. 3.17, wherein the point is made that '*Inspector Martin p.5728 notes that now and at p.6730 as a result of the publicity of the inquest clients are contacting fire engineers concerning interim measures*'.

commendable focus was on hardware solutions and apparently not on a wider risk management approach. Once the hardware solution was found not to be an option, the focus changed to completing the upgrade. A valuable risk management opportunity was lost.

It was about 18 months after the final discussions on interim measures that the fire occurred. By that stage there had been significant changes to Unit 31. The proposed upgrade was not complete. Alternatives to hardware solutions appear not to have been considered. As a lead-in to the quotation referred to in **3.14.1 Introduction: Relevance,** counsel for the MFB alluded to this issue when he said (in response to a question from the bench):

> *Coroner: See, let me spell out the difficulties. Now, obviously, Mr Taylor has worked with Kew's fire system for a number of years. He picks up on an issue and asks a question which relates to interim alarms. They – it is identified as being serious enough to put it in the questionnaires for the interviews for the consultants. How far does a reasonable person have to go to add to that?*
>
> *Mr Bell: That is the question for submissions, ... If Your Worship has a view that a reasonable person need go no further than that, then that is the answer to the question. But it may well be that a reasonable person knowing as much as Kew did as to the nature of the risk would need to go further. And what transpired we now know ... is that insufficient consideration was given to the interim measures question and no doubt the responsibility for that is something for which Mr Lai and Mr Cooper may well bear some blame, but on the evidence as it now is, it may well be a matter that exercises Your Worship's mind to ask, was there something in the system of engagement which led to an insufficient state of mind as to the seriousness of the question and the desirability of the consideration of the range of options which gave rise to that inadequacy. That, as I see it, ... goes most importantly to the manner in which questions of interim risks are dealt with in this kind of situation and if ever there was a situation over a period of years, it seems to me that, on behalf of the Fire Brigade, that needed to be addressed by way of interim measure, then it was this one. Yet the system failed to produce any measure when the evidence discloses at least some deserved serious consideration.*[400]

Essentially, at this stage, management failed in their duty to continue managing the risk. The major players in the first-line management decisions were all members of the PCG. Advice and recommendations had come from a variety of sources: the Fire Brigade, the Lumley, Dibben and ULA reports and the Fabric Survey. There was sufficient knowledge at KRS of the areas of greatest risk. The principal players – Messrs Taylor and Vasan – had been appropriately advising CMB of the risk for some time. Mr Savona (CMB) had knowledge of Dibben which was not imparted. He too had some knowledge of both Taylor's and Vasan's concerns.

If, as is submitted by the State of Victoria, '*a building by building'* approach was necessary for the 'fire audit', there was the perfect opportunity to revisit that work in Unit 31 during the 1995 renovations. In spite of a clear recommendation for the necessity to engage a fire engineer, ULA was not advised of the renovations until nearing completion. In failing to take that opportunity, management must bear the responsibility.

The history of fire events at KRS indicated that there was a probability of fire, that there was a significant likelihood of exposure of residents to that event and that the consequences (especially at night with low staffing levels and difficulties with evacuation) were serious. At night, with a large congregation of residents in one building, it was a high risk area. With the 1995 renovations

400 Transcript, pp. 5811-5812 (emphasis added). NOTE: Part of this quotation is used by the State of Victoria Submission in support of its argument on the level of responsibility of ULA/SSL: see discussion in **3.14.1 Introduction: Relevance.**

creating a more complex building and providing potential difficulties for staff on supervision and during evacuation, the problem was exacerbated. Management was well aware of the principal problem as evidenced by Mr Winn's statement about Vasan who understood that:

> *there were deficiencies in the quality of procedures and some equipment and documentation, and found him anxious that improvements be made at Kew. Srini Vasan specifically expressed his concerns about staffing levels at night and that this together with their lack of training would provide difficulty in effecting evacuation of residents in an emergency.*[401]

The approach to managing the risk at this time can also be seen in other evidence by Mr Vasan. When dealing with the 1995 renovations to Unit 31 and the certification by the building surveyor, he said:

> *Question: You were conscious, were you, as the works were proceeding, that the building when completed, in accordance with those works, would not meet acceptable fire safety standards?*
>
> *Answer: Yes, at that time, but we know we are going to do the upgrade within months, so it should have been done at that time.*[402]

Clearly, the concentration was on getting the upgrade completed. This was laudable. To their credit Messrs Taylor and Vasan had worked long and hard for that day. In the process of identifying and trying to find interim solutions, Taylor was in a difficult situation. This is evidenced in the following exchange between Messrs Redlich and Taylor:

> *Mr Redlich: ... So you were confused by the state of advice; or it – – –?*
>
> *Answer: We were confused by the fact that we didn't wish to proceed with an unapproved device and no-one was – and because there was the continuing change of face as to who was going to do the upgrade, it continually got delayed, if you like, until we were able to put it on someone's plate and say this is what we want, and we want it now.*[403]

However, in a situation where management had '*lost faith'* in the ageing fire alarm system, there was all the more reason to take control and manage the risk in the interim. This was not done.

Regardless of any argument that ULA failed to provide an interim hardware solution, there is no excuse for DHS neglecting to adopt non-hardware solutions or placing the residents back into a situation of risk.

3.14.5 CONCLUSION

The responsibility of management on this issue is clear. There was a failure to manage the risk.

The failure to draw together the many reports and recommendations on fire safety at KRS is a factor. It meant, for example, that the additional recommendations in the ULA Report did not receive the required level of attention. There was a failure to make the very necessary links between recommendations and significant inaction in a number of areas of fire safety by management at KRS. Guide posts to 'interim solutions' were suggested in many of the recommendations of the various reports over the years. These reports were not considered on a global basis by management to deal with the number of similar recommendations in each report.

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401 Exhibit 299 – Mr Winn, para. 11 (emphasis added). See also discussion in the Findings in **Part 2 Knowledge of the Risk and System Deficiencies 2.2.3 Consultants' Surveys and their Use (6) Scope of the 1994 'Audit': The Role of ULA and SSL.**

402 Transcript, pp. 6016-6017.

403 Transcript, p. 5207.

Whether the provision of interim hardware solutions throughout the complex prior to completion of the upgrade would have altered the outcome is a moot point. As suggested by counsel for SSL in one of his less strongly worded submissions:

> *There is just no evidence that any "interim" measure amounted to a "solution" which would have prevented the fire occurring or have led to lives being saved. Even if there were, that would not lead to the comfortable satisfaction that SSL breached a duty of care owed to those at Kew which was a cause of the fire or death by the provision of unreasonable advice or the unreasonable failure to advise. The most that can be said is that the world class experts did not and still do not believe there was any suitable interim solution per se.*[404]

Obviously, the interim hardware solutions being discussed by the engineers would not have had an effect on the commencement of the fire. Any hardware interim solutions would have been directed towards early warning and thus to rescue and fire reduction. It is also necessary to remember that the initial discussion on interim solutions took place well before KRS renovated Unit 31. The interim solutions having the potential to check the commencement of fire were: managing of fire-lighting risk and adequate supervisory staff in the light of the identified inadequacy of the fire safety system. It is necessary to remember that increasing staffing for fire emergency would have been limited to the interim period during upgrade.

One interim solution apparently not considered was the issue of moving the residents back into residence after the renovations and before the final upgrade.

404 SSL Submission, p. 28.

PART 4 SURVIVAL AND THE DETECTION SYSTEM ON 8 APRIL 1996

This Part deals with the evidence directed towards ascertaining the state of the fire alarm system on 8 April 1996. It is concluded that the alarm system operated at its limits at about seven (7) minutes 45 seconds after the fire started in the bedroom. It was probably a thermal detector that gave the alarm. This gave no chance for the residents to be rescued.

The system that was meant to be in place comprised smoke detectors in all the bedrooms (including the room of fire origin), which, if operating correctly, would have given the alarm within about 45 seconds. Because of fire damage, a lack of adequate plans and the number of contractors involved in maintenance and upgrade, there have been difficulties in precisely identifying the existing system and its operational state. After the fire, the MFB and two expert consultants have examined the material and the scene to assist in determining fire cause, sequence and the state of the alarm system.

There are a number of theories as to the state of the system and the cause of its failure. They range from resident damage and interference by the new system's installers – Wormald – to replacement of all smoke detectors with thermals in the bedrooms of Flat E by the maintenance contractor – Jonkar. Briefly, the theories are as follows:

- *Potential for inadequate maintenance (by Jonkar)*
- *Interference during fire alert system installation (by Wormald and/or its subcontractors)*
- *Interference during sprinkler system installation (by Wormald)*
- *Interference during airconditioning installation*
- *Damage to detectors (residents' actions/painting by KRS contractors)*
- *Integrity of existing system (positioning, number of detectors on circuits, wiring etc)*
- *Replacement of smoke detectors with thermals (by Jonkar).*

The potential for survival with a properly operating system is considered. An examination of the times and the evacuation on the night of the fire indicates that the outcome may well have been positive had there been a properly operating smoke detector in the bedroom of fire origin.

4.1 STATE OF THE FIRE ALARM SYSTEM ON 8 APRIL 1996

4.1.1 INTRODUCTION: FIRE SAFETY SYSTEMS AT THE TIME OF THE FIRE

Throughout the investigation, as a result of fire damage, a lack of adequate plans and a number of contractors being involved in maintenance and upgrade, there have been evidentiary difficulties in precisely identifying the existing system and its operational state. Since the fire, both the MFB and two expert consultants for various parties have been examining the alarm system to identify whether

or not anything went wrong. This process resulted in a considerable amount of examination and testing up to and during the inquest. See generally the Plans and Chronologies in Appendix 2 of the Findings.

Both the State of Victoria and Jonkar argued that all of the theories and possibilities were not sufficiently examined during the inquest, especially in areas involving Wormald. This is rejected. Witnesses were called and examined, additional statements were obtained, an on-site inspection was undertaken and the parties were given every opportunity to call or require additional evidence on a variety of matters[1] (see also the comments in the Findings in **4.1.13 Wormald's Alleged Involvement in the Investigation)**. In addition, the experts' conclusions did not provide sufficient direction to take the investigation any further in this area.

In Building 37, the early warning system did not provide local alarms. Mr L. Neicho described the system and sequence in the event of fire thus:

> *If a fire detector was activated in a residential unit not fitted with a sub panel (including Unit 30/31) an audible alarm signal did not sound in the unit. The main alarm panel was connected to the Fire Brigade. When a circuit went into alarm, a signal was sent to the Fire Brigade indicating a fire alarm. This signal did not indicate which circuit was in alarm.*[2]

It should be noted that in some of the other buildings at KRS local alarms were provided. There were no plans kept at KRS of the alarm system.

A plan of known facts about the existing detector system was prepared by Villamanta Legal Service as part of its submission. To assist with an understanding of the analysis of the various explanations, a copy of the plan is provided. The seat of the fire was in the bedroom at door 3. The plan also assists with an understanding of some of the evidence about other possible theories.

KEY FOR PLAN

?/(?) Not known	**39** Circuit number	**24** Detector number on circuit
T/(T) Thermal detector	**(S)** Smoke detector	

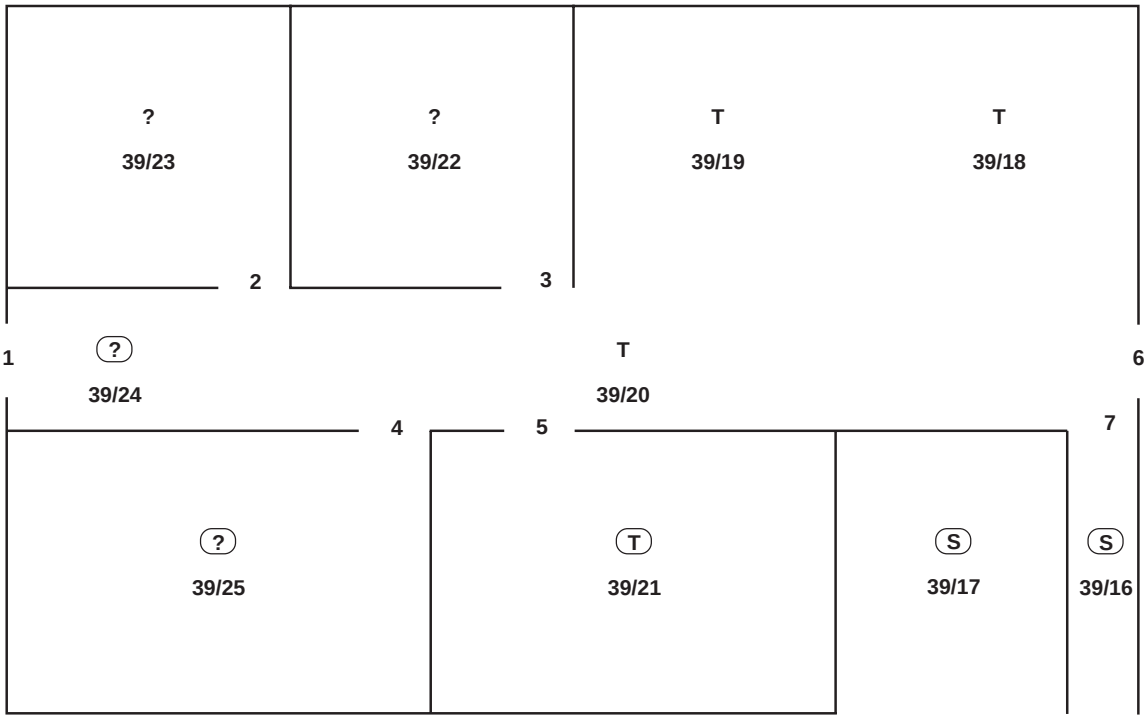
1 See MFB Reply, pp. 4-5, para. 10, where it is stated that:

As to paragraph 1.89 on page 192, the statement that Wormald's conduct was not able to he thoroughly scrutinised is completely incorrect. The Coroner and the parties conducted a special inspection of building 37, and in particular its roof space, to examine the issue of the wiring. Several witnesses were examined at length in relation to this issue. Wormald' s conduct was addressed in detail. The Coroner correctly decided after lengthy consideration of this evidence that there was an insufficient basis upon which to take the matter any further: see T5078-T5086, T5088. That decision was reached with the consent of all of the parties and in particular the Department of Human Services: see T5090, T5092, T5094-5. It was then decided to continue consideration of the issue given the evidence of Mr Tregonning: T5096-7. At the end of Mr Tregonning's evidence on 18 March 1997 the Department was given the opportunity to "run" the issue in full: T5163. Counsel for the Department declined that opportunity: T5166. Every party had the opportunity to submit that a different course be adopted, and none did.

See also comments on Jonkar's opportunity to test the Wormald related matters in MFB Reply, p.11, para. 35.

2 Exhibit 193, p. 8, para. 17.

Known position and types of detectors in Flat E after the fire.



4.1.2 CLUES TO THE STATE OF THE SYSTEM: EXPERTS' VIEWS AND CONSULTANTS' SURVEYS

(1) EXPERTS' VIEWS ON THE FIRE

To assist in the investigation, DHS commissioned consultants to report on the fire – Mr J.P. England of Warrington Fire Research. Two other experts were also involved – Inspector Gary Martin, Fire Investigation Unit, MFB and Mr Daryl Knight on behalf of the Parents' Association. After completing their reports, and following consultation, the experts made a joint statement on the issues elucidated during their work. That statement reads (in part):

> *... The experts concurred that the tests conducted by the Metropolitan Fire Brigade were a reasonable summation of the events at Kew on the 8th April 1996.*
>
> *Mr Knight did not see any need to pursue discussion relative to the time lines of events as he did not believe them to be an issue.*
>
> *... Re 4.6 of Mr England's report discussing the failure of the alarm system – all agreed that this scenario was but one of many. There is no evidence to support this particular failure however, it was agreed that a failure of some nature had occurred.*[3]

The three experts agreed '*that there were no major areas of disagreement with the reports and that only minor areas, of such a nature that they did not impact on the outcomes, existed'*.

Significantly, the Warrington Report notes that '*[d]esign documentation, invoices for work undertaken, audits by Umow Lai and Associates and documents for the fire safety upgrade all*

3 Exhibit 286 – Notes of Meeting held 15 April 1997.

identify smoke detectors in the bedrooms of Flat E, and in Flat B of units 30 and 31'.[4] But, it is also noted that '*after the fire incident Heat Detectors were observed in Flat B. These heat detectors were identified as Hokichi. Refer to Appendix 1 and section 2 of this report for further details of the detection system'*.[5] The fact that the adjoining Flat B had thermal detectors installed rather than smoke detectors adds to the difficulty in accepting the confident assertion by Jonkar that smoke detectors remained in Flat E. The Warrington Report concludes that:

> *if heat detectors were installed in lieu of smoke detectors in the bedrooms of Flat E, an extended time to alarm would occur which could approach 7 minutes.*[6]

Further, it concludes that:

> *[a] 7 min. 45 second activation time would be compatible with the operation of a heat detector in, for example, the corridor distant from the room of origin if the smoke detectors in the bedrooms had failed, or for a poorly positioned or damaged heat detector in the room of fire origin. For example it is common practice to test heat detectors using light bulbs within a cylinder rather than specialist equipment. If a relatively high powered bulb is used, the heating rate may be excessive and reduce the sensitivity of a heat detector. Poor siting of detectors and over-painting can also delay the response of the heat detectors.*[7]

As an alternative, Warrington considers that '*complete failure of the below ceiling detection system in Flat E'* could have been an explanation. In this case reliance would be placed on an adjoining area's system for the alarm.

Further, the Warrington Report comments that '*[a] detailed investigation of the remaining wiring after the fire was unable to confirm the status of the detection system within Flat E at the time of the fire due to the extent of the fire damage. Details of the investigation are included in Appendix 1'*.[8] Warrington also indicates that, to a limited extent, original steel conduits housed the below ceiling detectors (and the roof space thermals). The report also comments that:

> *[t]he substitution of heat detectors for smoke detectors in Flat B and non-compliances with AS I670 such as providing joints in the cabling with cable lengths less than 100m and without junction boxes, together with the age of the cabling within the conduits, raise questions as to the performance and reliability of the detection system which was in place at the time of the fire.*[9]

Non-compliance with Australian Standards for detection systems are noted as including:

- *provision of numerous joints in cabling with plastic connections or in one case, twisted wiring*
- *too many detectors on one circuit*
- *detectors close to supply air inlets and lights*
- *damaged/overpainted detectors.*[10]

As to the 'rapid' fire growth (and the consequence for the conclusion on the state of the detection system), Warrington considers that:

4 Exhibit 201, p. 16.

5 Exhibit 201, p. 16.

6 Exhibit 201, p. 16.

7 Exhibit 201, p. 16.

8 Exhibit 201, p. 16.

9 Exhibit 201, p. 33 (see Appendix 1 of Exhibit 201).

10 Exhibit 201, p. 17.

[i]f smoke detectors were installed in Flat E and operated correctly, then a substantially faster fire growth rate would have been necessary to be consistent with the observations of the witnesses (ie. a fire reaching flashover within 5 minutes of ignition).

It has been demonstrated that a conventional non-fire rated polyurethane foam mattress could cause flashover in a small room in approximately 4 minutes if subjected to a large flaming source (i.e. a burning waste basket).

The room was large (housing 3 clients), the mattress was protected by a Medishield mattress cover and the potential for a large flaming source such as a waste bin being present in a bedroom in Flat E was low.

It is noted that the fire investigation did not identify an alternative item that could have been initially ignited, and the large number of preliminary tests did not demonstrate an immediate rapid fire growth rate.[11]

The report concludes that:

the probability of a fire leading to flashover in a bedroom of Flat E within 5 minutes of ignition is very low.

It is therefore reasonable to conclude that the most likely scenario would be similar to the simulation test performed at Port Melbourne by the MFB and that activation of the alarms must have occurred 7 or more minutes after ignition compared to approximately 45s which would be expected if a functional smoke detection system had been present in Flat E.[12]

As to the probability of failure of smoke detectors, the report states:

Since a number of non-compliances with the design code were identified in Units 30 and 31, it is considered that the system would have a below average reliability and therefore there was a significant probability for failure of the detection system in place at the time of the fire.[13]

In another report prepared on this issue, Inspector Martin considers that, given the expected operation of a correctly positioned smoke detector at approximately 40 seconds, the smoke detector alarm has not occurred in the compartment of fire origin.[14] He also concludes that the alarm operated on loop (39) and confirms, at the least, partial operation of the loop. He considers that a thermal in the room of fire origin may have operated in approximately seven minutes given incorrect positioning, sensitivity by painting, incorrect test methods or dust accumulation. More importantly, Martin is of the view that:

[b]ased on the test results by the M.F.B, combined with my own experience, smoke detector operation in adjoining rooms such as the hallway of flat E, the bedroom accessed by door 2 and the bedroom accessed by door 4 would be expected to occur in approximately 150 seconds. As such, the operation of smoke detectors in these compartments are also excluded.[15]

Inspector Martin opines that, based on the tests, '*detector operation of a thermal outside of the room of fire origin, such as the thermal indicated in the hallway at position 39/20 on the Jonkar January Plan) would have occurred some 8 minutes after ignition. This would be consistent with*

11 Exhibit 201, p. 17.

12 Exhibit 201, p. 17.

13 Exhibit 201, p. 17.

14 Exhibit 222, para. 6.

15 Exhibit 222, para. 7.

the delay in alarm, following ignition of the fire'.[16] The operation of the smoke detector at position 39/17 (closest bedroom to E in Flat C) on the January Plan is considered unlikely. Martin considers that earlier operation of a thermal nearer to the compartment of fire origin (39/20) would have been expected in advance of 39/17.

The fact that door 7 was open in the early stages of the fire (Chea's evidence) leads Martin to conclude that:

> *39/16 ... if it existed, would have functioned prior to the operation of a thermal in other rooms within Flat E, other than possibly the operation of the thermal detector located at position 39/20, or, if operational, the bedroom of fire origin. (Based on the observations of Earpeng) the smoke layer within the Flat E lounge room was down to approximately 1 metre above floor level, therefore the existence of smoke at the ceiling within the hallway connecting Flats C & E would have been expected.*[17]

In addition, Inspector Martin concludes:

- *Smoke detector activation within Flat E proper has not occurred.*
- *Thermal detector activation is possible in room of origin given certain criteria, ie. sensitivity effected by incorrect positioning, incorrect testing, or, painting of detector.*
- *Loop established into Flat E was operational, at least in part, at the time of alarm.*
- *Thermal detector operation (position 39/20) within hallway of Flat E is possible given time lines.*
- *Smoke detector operation (position 39/16) within hallway of C & E is possible.*[18]

The reasons for the late notification of the fire are: '*[n]o smoke detectors present within Flat E; Continuity of circuits compromised; Damaged detectors; Thermal in place of smoke painted detector; Accumulation of dust; Incorrect positioning; Sensitivity effected by incorrect test method*'.[19]

At the start of his report, Martin notes that:

> *[e]xcluding Flat E, the corridor between Flat C & Flat E and the bedroom accessed by door 9, only two smoke detectors existed (39/4 & 39/39 as referenced on the Jonkar January Plan). One detector (39/4) was located within a bedroom in the south/east section of Flat D and the second (39/39) was located at the extreme limit of the corridor accessing the bedrooms of Flat B (outside door 46).*[20]

It was considered unlikely that the smoke detectors (39/39 and 39/4), both at either end of Building 37, operated.

As noted earlier, Warrington also alludes to the fact that remaining detectors in Building 37 throw considerable doubt on the accuracy of the 'January Plan'. In view of its major inaccuracies, the 'January Plan' is not considered by the court to be a reliable document.[21]

(2) CONSULTANTS' SURVEYS

One possible clue as to the state of the system is to be found in the *'Fabric Survey & Building Utilisation Study: Part A Kew Cottages'*.[22] This document was completed in September 1994 by

16 Exhibit 222, para. 9.

17 Exhibit 222, para. 12.

18 Exhibit 222.

19 Exhibit 222.

20 Exhibit 222.

21 See also discussion in the Findings in **4.1.10 Fire Alarm Plans for Units 30/31 and the 'January Plan'**.

22 Exhibit 128.

Group 4 Design Pty Ltd. It contains considerable detail on the fabric of all buildings on the site. The section on Building 37 (marked in the survey as 'Building No: 45 – Units 30 & 31') indicates that it was inspected in May 1994. The three page section of the report relevant to Building 37 comments that the building is partly refurbished. Under the heading, 'FIRE ALARM SYSTEM', it shows 'Thermal' 'Old – Y', 'New – Y'. Under 'Smoke', an 'X' is marked in the box marked 'N' while the box marked 'Y' is blank. The survey goes on to indicate N (no) audible alarms; N (no) electric door strikes; and Y (yes) to break-glass alarms. Under the heading, 'HYDRAULIC SERVICES, FIRE SERVICE', it comments 'No internal fire protection'. The services are marked N (no) to hose reels, internal hydrants and sprinklers. The Fabric Survey appears to conclude that there were no smoke detectors in Building 37 in May 1994.

One would expect alarm bells to ring loudly in the ears of management, particularly given the then existing government guidelines regarding smoke detectors. Similarly, this is such a significant survey finding that it was imperative that it be highlighted to those in charge at KRS. Indeed KRS management and staff were recorded as being on the 'Project Team', and thus there would appear to be no excuse for a break in the information chain.

Looking at McCumisky's (MFB) survey[23] of the state of the alarm system after the fire, there remained (after the fire) only two hard-wired smoke detectors throughout the building (Flat B: corridor near door 45; and Flat D: bedroom door 24). Also there were two domestic-type smoke detectors (not linked to the central alarm panel at Administration) positioned in Flats A and B near doors 49 and 60 – both in living areas.

It would appear unlikely that a detailed fabric survey would miss a significant smoke detector presence in seven of the bedrooms and corridors that were, a few months later, to become Flat E (and part of Flat C). On the evidence, there should have been ten smoke detectors installed by Jonkar (S. Moore) in September 1993. In addition, Flat B should have had a significant number of smoke detectors at this time. It may be reasonable to miss four smoke detectors (two hard-wired and two domestic) interspersed throughout the whole of Building 37. But, to miss a significant number of smoke detectors, all located in one area, raises some questions. It is noted that those who prepared the Fabric Survey were not called to give evidence; accordingly, this material must be viewed with some circumspection.

The ULA Report, with SSL's report, does not identify, in the same detail as the '*Fabric Survey & Building Utilisation Study: Part A Kew Cottages'*, the state of the hardware in Building 37. The material made available under the ULA Report is deficient in this area. It comments in relation to Unit 31, under the heading '*Special Hazards'*, '*smoke detectors in rooms and corridors. Heat detectors – old Eps discoloured in kitchen, laundries, dayroom'*. The ULA Report was delivered in August 1994 and the Fabric Survey in September the same year. While both were critical of the state of the alarm system, one provides more detail.

4.1.3 THE VARIOUS THEORIES ON THE STATE OF THE SYSTEM

(1) INCIPIENT OR RAPID FIRE GROWTH?

As a starting point for the various theories, it is necessary to examine whether or not the fire rapidly grew from ignition or was of an incipient type that took considerable time to reach a critical stage.

Jonkar's Submission suggests that there is '*no evidence that the fire detectors in Flat E did not operate effectively on the night of the fire. On the contrary, the clear evidence from the MFB is that*

23 Exhibit 186.

they received notification about the fire as a result of the operation of a fire detector at Kew Cottages. The evidence shows that circuit 39 operated and circuit 40 operated shortly thereafter. This is entirely consistent with the expected operation of the fire detection system in building 37'.[24] Unfortunately, this submission does not deal adequately with the expert evidence of Messrs England, Martin or Knight.[25]

In an attempt to explain a significant delay in the operation of the system, Jonkar also argues that '*[t]he allegation that any smoke detector in bedroom 3 failed to operate on the night of the fire relies on the fire tests conducted by Inspector Martin. Those fire tests were all conducted in a pristine environment. The result may well have been significantly different if combustible material such as magazines, paper and other rubbish had been placed beside and under the bed. The result may also have been significantly different if the fire had been lit in more than one place'*.[26] There was no evidence of any magazines, paper or other rubbish placed beside or under the bed.

Other suggested explanations for rapid increase in fire came from Messrs England and Kelleher. After observing the 'fire test', Mr Kelleher commented that:

> *heat from the burning bedding degrades the mattress cover, so that collecting bedding at one end of the bed is likely to speed the development of a fire ...* [and] *... the apparent speed of the original fire relative to the test burn and to the observed pattern of burning of the bedding, suggested that the bedding may have been ignited in more than one place.*

Accordingly, it is considered unlikely that a substantially faster fire growth occurred in the bedroom of fire origin than that illustrated by the MFB fire test and discussed by the experts.

The evidence is overwhelming that the smoke detector system (if installed) did not operate correctly. Simply put, circuit 39 operated at its limits which was not consistent with a functioning smoke detector in the bedroom of fire origin. Thus, on the state of the evidence, it is possible to say, at the highest, that there was no 'operating' smoke detector in the room of fire origin. Whether or not a smoke detector was actually in position is another matter.

(2) SUMMARY OF THEORIES

Putting aside Jonkar's theory on the fire growth, various theories are posed to indicate the likely state of the detection system in the room of fire origin and Unit 31. Briefly, they are as follows:

- potential for inadequate maintenance (by Jonkar)
- interference during fire alert system installation (by Wormald and/or its sub-contractors)
- interference during sprinkler system installation (by Wormald)
- interference during airconditioning installation
- damage to detectors (residents' actions/painting by KRS contractors)
- integrity of existing system (positioning, number of detectors on circuits, wiring etc)
- replacement of smoke detectors with thermals (by Jonkar).

4.1.4 MAINTENANCE: EFFECT ON THE EXISTING SYSTEM

(1) EXPERTS' VIEWS

The comments of the Warrington Report on noncompliance with Australian Standards are telling. There was every potential, in view of problems with both system design and maintenance, for alarms to fail. For example, many issues remained to be corrected:

24 Jonkar Submission, p. 10, para. D1.

25 See also discussion in the Findings in **4.1.2 Clues to the State of the System: Experts' Views and Consultants' Surveys.**

26 Jonkar Submission, pp. 10-11, para. D2.

- *provision of numerous joints in cabling with plastic connections or in one case, twisted wiring;*
- *too many detectors on one circuit;*
- *detectors close to supply air inlets and lights;*
- *damaged/overpainted detectors.*[27]

All added to the potential for alarm failure. Warrington considers that the probability of failure of smoke detectors raises concern about system reliability:

> *Since a number of non-compliances with the design code were identified in Units 30 and 31, it is considered that the system would have a below average reliability and therefore there was a significant probability for failure of the detection system in place at the time of the fire.*[28]

(2) COUNSELS' SUBMISSIONS

An important issue is whether or not the numerous breaches of the Australian Standards resulted in a compromise to the system on the night of the fire. The issue of whether Jonkar replaced smoke detectors with thermals in the bedroom of fire origin or other bedrooms in Flat E is considered to be a separate matter.

There were many areas in which the contractor Jonkar failed to comply with the terms of its maintenance agreement: Australian Standards were breached; smoke detectors were regularly and inappropriately replaced with thermal detectors; KRS was not advised of the many problems relating to noncompliance with Standards that Jonkar saw during its work at the complex. As already mentioned, the State of Victoria's Submission lists the following areas where Jonkar breached its duties:

> *(1) Incorrectly placing detectors and/or failing to rectify the incorrect placement of detectors;*
>
> *(2) Failing to perform a thorough visual inspection of detectors for factors that could adversely affect their functioning;*
>
> *(3) Installing and/or failing to rectify the installation of an excessive number of detectors on Circuit 39;*
>
> *(4) Failing to ascertain the status and verify the integrity of wiring in Unit 30/31 failing to inform BSA or KRS of any potential deficiencies as a result of faulty or aged wiring.*
>
> *(5) Keeping poor records and inadequate plans,*
>
> *(6) Insufficient training, instruction and supervision of Jonkar Staff.*[29]

A number of opposing views were put forward regarding the effect of the breach of Australian Standards. For example, Jonkar put that the view that '*the State of Victoria knew that its fire detection system did not even begin to comply with the relevant Australian Standards. Nonetheless, it purported to require its contractor to comply with the Australian Standards'*.[30] Further, Jonkar submitted that the reason that Standards were not raised was because '*compliance by Jonkar was not required. It was an impossibility'*.[31] Arguing the contractual issue, Jonkar stated that:

27 Exhibit 201, p. 17.

28 Exhibit 201, p. 17.

29 State of Victoria Submission, p. 230, para. 1.215.

30 Jonkar Reply, p. 14, para. 3.6.

31 Jonkar Reply, p. 14, para. 3.7.

> *while the standard form contract issued to Jonkar contained a reference to the requirements of the Australian Standards, it is clear that compliance was waived by the State of Victoria. With full knowledge of the circumstances, the State of Victoria renewed Jonkar's contract year in year out. Jonkar was required to perform the contract "to the satisfaction of the Superintendent of the Ministry". The Superintendent for the majority of the time from 1991 to the date of the fire was Mr Stewart. Mr Stewart was clearly satisfied with the performance of Jonkar.*

This submission ignores the fact that there was no technical audit of Jonkar's maintenance work. Thus, the State of Victoria did not have full knowledge of the circumstances, and also it was not advised of the circumstances by Jonkar.

The Parents' Association argues that there was a practice of removing smoke detectors and failing to reinstall them when appropriate, and a failure *'to keep track of changes in detectors and to appreciate the effect that these changes were having on the efficacy of the protection system'*.[32] It adds that most *'of the plans kept by Jonkar did not reflect the current state of the detection system of the subject building'*.[33] The Parents' Association argues the contrary view to Jonkar when it says that the failure to keep proper records:

> *meant that at no time did they* [the State of Victoria] *have a coherent and comprehensive picture of what was going on in the field in the buildings in KRS and, in particular, in Building 37. Accordingly, they were not in a position to become aware of and appreciate any deterioration in the quality or level of protection afforded within the various buildings at KRS and in this instance to appreciate the dangerous position that developed in building 37. The failure to keep proper records was in a sense a product of the approach adopted by Mr L. Neicho to the task his company had undertaken which seemed to amount essentially to the proposition that as long as the system was kept running all would be well.*[34]

Of the changing of detectors from smoke to thermal, the Parents' Association submits that:

> *[p]art of the approach of keeping it running involved the minimisation of false alarms and led to the adoption of the dangerous practice of replacing smoke detectors with thermal detectors. It seems no one in the organisation properly appreciated the risk that such a practice might present to the efficacy of the fire protection system. If they had there surely would have been a system of constant monitoring to ensure that adequate smoke detection in bedrooms and corridors was always maintained.*[35]

Put somewhat bluntly, the Parents' Association says in its Reply to Jonkar's submissions:

> *It was the blind leading the blind. Jonkar failed to appreciate the effect its removal of smoke detectors was having and nothing in the testing it conducted would have alerted it. No one at KRS or in Human Services or BSA was capable of appreciating what was going on unless Jonkar had told them.*[36]

It is difficult to argue with this submission.

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32 Parents' Association Submission, p. 123, para. 355.

33 Parents' Association Submission, p. 124, para. 359.

34 Parents' Association Submission, p. 125, para. 361.

35 Parents' Association Submission, p. 125, para. 361.

36 Parents' Association Reply to Jonkar's Submissions, p. 2, para. B4.

4.1.5 FIRE ALERT SYSTEM INSTALLATION: POTENTIAL TO AFFECT EXISTING ALARMS

(1) INTERFERENCE DURING INSTALLATION AND THE 'CUT IN' THEORY

Mr Robert Tregonning, electrical mechanic at Wormald, was the site foreperson for the upgrade at KRS. Tregonning recalled that:

> *an electrician approached him for permission to disconnect a section of existing wiring and to use it to pull new wiring through to a break glass alarm, strobe light and bell in a hard to access area. I was initially reluctant to allow this to be done but was convinced that it was the only practical method to use. I allowed the disconnection at a point where there was an existing blue-point junction on the existing wiring. After the work was done, I personally reconnected the blue-point junction. On day of changeover a new junction box would have been installed at that point. When the cable was re-connected, I checked the panel and it was in alarm. This indicated a reverse polarity. I went back to the building and used a multi-meter to confirm that it was reverse polarity. I reversed the connections and then went back to the FIP. The circuit re-set and was left normal with no faults and no alarm.*[37]

Later, after giving evidence at the inquest and during an inspection of the roof space in the area of the 'blue-point junction', Mr Tregonning realised he was mistaken. It is noted that at the inquest his earlier evidence on this issue was firm. Mr Tregonning initially thought that this disconnection took place in Flat B.

At inspection there was no physical evidence of a 'pull through' in the area of Flat B. In any event it was not necessary as there was adequate space in the roof for work on wiring. Tregonning, in evidence after the inspection, indicated his earlier evidence about this issue was wrong. After an inspection of all the buildings subject to the upgrade, Mr Tregonning was not able to identify where the 'pull through' occurred. In fact he was not able to say that it was in the Kew complex.

While it remains difficult to understand why Mr Tregonning mistook the area where he suggested that he originally worked, the fact is that he made a mistake. A physical inspection indicates that the work he gave evidence about could not have occurred in the Flat B area.

The State of Victoria argued that the circuit was cut by Mr Tregonning at Flat E to run new addressable wiring in Flat E. This was not necessary as the existing wiring for Flat E was to be used for the new system (see also discussion in the Findings in this section in **(3) The Bypass Theory)**. Mr Russell Harris of Ellas Electrics, who wired the bell and strobe light in Flat E, stated:

> *I remember doing the Flat E bell and strobe cabling because it was a squeeze to get the cable through from the gabled section to the flat roof section. I had to lie down and crawl in as far as I could. Then someone from ground level pushed a piece of yellow tongue up through a hole we had drilled in the ceiling. I then taped the new cable to the yellow tongue and the person below pulled the new cable down to the bell and strobe. The bell and the strobe were on new cable. There was no need to use a draw wire nor to disconnect any of the existing cabling to do this work.*
>
> *I do not remember the disconnection and re-connection referred to by Robert Tregonning. I do not believe that any of the electricians would have done this work without asking Robert Tregonning's permission. Bruce Hoskin, Robert Tregonning and Nick Kamaros had stressed the fact that we had to be careful not to do anything to disturb the operation*

37 Exhibit 223.

of the old fire protection system and to be careful in the course of our work not to stand on the old cabling or knock it with our tools. We clearly knew that we were not to work on the existing cabling or detectors until the day of changeover. We knew the old system had to be up and running each day at the end of work because the residents were continuing to live there. We were not allowed to leave work each day until Robert confirmed that the old system was back on.

It has been suggested that one of the electricians might have done a by-pass of the detectors in Flat E. I did not do any such by-pass and I cannot think of any reason for us to have done so. I do not believe any of the other electricians did so. I did not see any by-pass of the existing detectors in this or any other building at Kew.[38]

Mr Harris' statement has relevance to a number of the allegations as to interference by Wormald or its subcontractors. He was not called to give evidence.

The State of Victoria's Reply puts the 'Tregonning circuit cut' as a 'prominent explanation of the systems failure'.[39] It is noted that Jonkar's Reply argues:

Wormalds seek to dismiss the possibility of Mr Tregonning's disconnection occurring in Flat E by relying on the evidence of Mr Harris that he did the bell and strobe light wiring in Flat E. This evidence actually creates more problems for Wormalds than it solves. Mr Tregonning " knew" that he had cut into circuit 39. There is now no question that it was not Flat B. The only other plausible alternative is Flat E. If Mr Harris' evidence is to be accepted, Mr Tregonning's "innocent" explanation for his cut-in (that he wanted to pull through the wiring for a bell and strobe) is no longer available. In circumstances where Wormalds had raced ahead of their original work schedule, where Mr Tregonning would have anticipated switching over to the new system very shortly, where he had little regard for the existing system – it is entirely possible that he cut-in to the existing system to connect new detectors.[40]

It is also possible that any 'cut in' did not occur in Building 37. There is no evidence that Mr Tregonning had little regard for the existing system. He checked that fire indicator panel (FIP) to ensure that the system was working on a regular basis. There is no evidence that Wormald were 'racing ahead' although they were ahead of schedule. The Jonkar submission is not preferred.

In addition, the court inspected the area in March of this year and did not observe any material that would require further investigation on this issue.

(2) REMOVAL OF DETECTORS BY WORMALD

It was argued by the State of Victoria that there were two competing hypotheses for the lack of smoke detectors (if this was in fact the case) in the room of fire origin. One of these is that Wormald disconnected the detector and replaced it with a new addressable detector after 16 January 1996. The installation of any addressable detectors on circuit 39 would have compromised the operation of the existing alarm system. The closest new addressable detector installed was in Flat B. None was recorded as having been installed in Flat E or Unit 31.

In support of the hypothesis, the State of Victoria's submission[41] relies on the evidence of Mr Lai that he observed a 'new addressable' detector in the bedroom at 'door 9' during a visit to the site after the fire on 10 April 1996. Later, in October following an on-site inspection with Mr Olle, Lai

38 Exhibit 243 - Mr Harris' statement dated 23/3/97.

39 State of Victoria Submission in Reply, p. 507, para. 1.123.

40 Jonkar Reply, p. 20, para. 3.22.

41 State of Victoria Submission, pp. 215-220.

changed his view of this detector and considered that it might have been a conventional LED smoke detector.[42] The submission, in examining in some detail why he was not mistaken in his original assessment, deals with his expertise in identifying types of detectors, his knowledge of the consequences and the failure to advise the MFB or the State's legal team.

Against this is the fact that Mr Lai's evidence is to the effect that, on reflection, he was mistaken. Having viewed Mr Lai in the witness box for a number of days, the court is of the view that he was an impressive, concerned and believable witness. He was concerned enough to mention the fact to the legal team for the State of Victoria and to take the opportunity of attending on-site in an attempt to assist with his recollection. The court accepts that Lai was genuinely mistaken. A photograph of the detector at door 9 shows a conventional smoke detector. This is also supportive of Mr Lai's final assessment.[43]

Neither Mr Tregonning nor the answers of the Ellas electricians are supportive of this theory.[44] Mr Tregonning's evidence on this issue is:

> *Question: ... [J]ust finally, Mr Treggonning, you are not in a position now to say whether or not there were new addressable smoke detectors; for example, in Flat E.*
>
> *Answer: There was no new addressable detectors in Flat E.*
>
> *Question: How do you know?*
>
> *Answer: We hadn't started changeover.*

Later, as to the possibility that others (Wormald/Ellas), Tregonning gives evidence to the effect:

> *Question: ... Are you saying this. If a worker, be it Wormald or Ellis, put detectors on the wiring a, or some, new addressable smoke detectors in that area, they didn't let you know that?*
>
> *Answer: Sorry?*
>
> *Question: They didn't tell you, or get your permission – ?*
>
> *Answer: They were only – they were only putting new addressable detectors on new wiring.*
>
> *Question: And you told that clearly?*
>
> *Answer: Yes.*
>
> *Question: Not to interfere with the old wiring?*
>
> *Answer: Yes.*
>
> *Question: And don't put new detectors up?*
>
> *Answer: Only on the new wiring.*
>
> *Question: Because the fact is, if they did that, for example, it wouldn't work – the detector wouldn't work and it wouldn't go into fault, would it?*
>
> *Answer: That detector wouldn't work, no. ...*
>
> *Question: You know where they put new addressable detectors in any rooms in that building; is that what you are saying?*
>
> *Answer: No, they put new addressable detectors on new wiring only, and they hadn't – we hadn't done any changeovers. They knew – they knew that would happen on the last day. ...*
>
> *They weren't testing or doing any of that sort of thing, they were only running new wiring, and that's all they were doing.*[45]

42 See generally evidence and discussion in Transcript, pp. 3023-3049.

43 Exhibit 147.

44 Exhibit 230 - Ellas Electrics 'answers'.

45 See generally Mr Tregonning's evidence in Transcript, p. 5126 et seq.

Mr Tregonning checked the alarm panel on completion of the work in Flat E (17/1/1996) and did not observe a fault light for circuit 39. He regularly had to check the panel for other work on the site after that date and did not observe a fault light on 39. Evidently, there were a number of new addressable detectors installed in situ but not connected to the existing wiring throughout the building. He considered that addressable detectors may have been installed in skylights. Apparently, there is one marked on the drawings for the bedroom at door 9. On this issue the following exchange took place:

> *Question: ... Can I confirm to you that there was a skylight in that room on the shop drawing?*
>
> *Answer: Yes.*
>
> *Question: Is it possible that (indistinct) a detector there, was it?*
>
> *Answer: Yes, it's possible.*
>
> *Question: And Mr Treggonning, did you ever observe in any of the buildings that you upgraded there, an instance of a worker connecting a new addressable detector to the existing wiring?*
>
> *Answer: No.*[46]

The Wormald Submission (relating to the 'bypass theory') explains this point in the following terms:

> *new wiring had been run to places where new detectors were to be located. In some instances the new detectors or bases had been fitted to the new wiring but this was not connected to the existing circuits. Evidence of this can still be seen in building 37: for example, nearly all the roofspace detectors, in the skylights in Unit 30, and in the bathroom of door 20.*[47]

However, Inspector Martin deposed that the MFB did not discover any new addressable detector connected to circuit 39 in the undamaged section of Unit 31. It has also been suggested that the 'addressable' detector originally identified by Lai was in the corridor to Flat E. The video of the Loss Assessor shows some of that area prior to demolition and Martin was not able to identify any detector. The Wormald Submission makes the point:

> *If a new addressable detector had been connected to the system at 39/16 (the corridor), that particular detector would not have functioned. But that detector would not have prevented any of the other detectors from functioning.*[48]

Thus, as there is no other evidence to support the installation and connection of addressable detectors in Flat E or Unit 31, the finding is that this hypothesis is unlikely.

(3) THE 'BYPASS' THEORY

The 'bypass theory' is dealt with in some detail in the State of Victoria Submissions and Reply (1.136-1.164 and 1.109-1.112 respectively) and Wormald's Submissions and Reply (1.14-1.16 and 3.1-3.29 respectively). Essentially, it is a theory, and the evidence on which it relies is supposition. The relevance of this issue is explained in Wormald's summary of the State's Submission:

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46 Transcript, p. 5135.

47 See Exhibit 215 - Mr Hoskin's statement, p. 5; Exhibit 230 - Ellas electricians. See Wormald Submission, para. 3.25.

48 Wormald Submission, p. 29.

[T]he reason smoke detectors in Flat E may not have operated is that Wormald had done a wiring bypass which it forgot to undo in the rush to leave Unit 30/31 on the day asbestos was found in the roofspace. DHS suggests the motive for the bypass may have been to save time on the day of changeover or to avoid false alarms in Flat E.[49]

After the fire, in unburnt areas of the building, Mr McCumisky, MFB, found that the wiring was continuous and no evidence of any bypass was discovered.

Basically, there is no firm evidence that a 'bypass' occurred. It is one hypothesis that relies on the finding of an unburnt conventional detector in the debris of Flat E. It is suggested that Wormald transferred it from Flats E to C (at position 39/26) during a bypass. Unfortunately, there has been no evidence as to where this unburnt detector originated. It is pure speculation as to its origins in the context of the clean up after the fire. In addition, the Wormald's Submission poses the question:

It is inconceivable that a contractor seeking to save time and avoid false alarms by removing smoke detectors would then replace a thermal detector with a smoke detector at 39/26 or anywhere else. A contractor seeking to avoid false alarms from smoke detectors would have simply left the thermal detector where it was.[50]

There are a number of other points of contention on the issue that require examination before the bypass theory can be concluded. Unfortunately, each hypothesise on material that cannot be proved. For each there are reasonable and practical answers:

(1) Wormald was under the pressure of time. The Wormald position is that '*[o]n evidence accepted by DHS (DHS 1.140), when work ceased on 17/1/96, Wormald had completed 70% of the work in the building but it had used only 50% of the five days allocated to the job'*.[51] This does not indicate time pressure. The contrary submission relies on supposition from minutes of site meetings with no expert evidence of what should have been completed at the end of each day. In addition, there was no substantive evidence to indicate time was running behind.

(2) A motive for a 'bypass' was to reduce the possibility of false alarms from smoke detectors. Inspector Martin undertook a test drilling 12 holes in plaster board near a conventional smoke detector. Dust from drilling did not set the smoke detectors into alarm. Thus it appears an unlikely hypothesis that work on the site by Wormald would set the detectors into alarm thus necessitating a bypass.[52]

(3) Welding work has the potential to cause false alarms. Evidently, welding was taking place above the skillion roof. The Wormald Submission puts the theory as unlikely as, in the event it did occur, the solution was not to bypass but to reset the alarm at the Fire Panel in Administration on the completion of the day's work.

(4) The time-consuming nature of doing a 'bypass'. It is accepted that a 'bypass' is not a simple matter of disconnecting and re-connecting wires to a detector. It requires tracing of wires (that may be under insulation) to other detectors in a sequence. There were no 'as wired drawings'. Thus, it would be reasonable to conclude this would take considerable time and would not be consistent with a work schedule that was 70 per cent complete.

(5) New wiring for addressable detectors. The fact that new wiring was discovered in the bathrooms near to Flat E (doors 10 and 20) does not suggest that new wiring was required for Flat E

49 Wormald Submission in Reply, para. 3.1.

50 Wormald Submission, para. 3.5.

51 Wormald Submission, para. 3.8; see also paras. 3.9-3.11.

52 See also comments in Findings in **4.1.6 Sprinkler System Installation: Potential to Affect Existing Alarm.**

detectors. All that was required for Flat E was already provided by new wiring installed in 1993. All that was required for Flat E on the final changeover day was to exchange 'new for old'.[53] In fact there were no detectors in these two bathrooms, and thus new wiring was required to be run for those detectors only.[54]

(6) Wormald's work practice was to check the integrity of the wiring on the day of changeover after fitting of all the new addressable detectors to the system. There is no evidence to suggest that they did in fact adopt any other course (i.e. by disconnecting every detector and metering the wiring). This course would require more work and appears not to be logical.[55]

(7) There is no evidence to indicate that the electricians working for Ellas bypassed the system.[56]

Examination of all of the submissions and the inquest evidence does not result in a conclusion that the 'bypass theory' is likely.

(4) THE 'REVERSE POLARITY' THEORY

The State of Victoria argued that, where detectors are wired in reverse polarity, a fault will not be registered on the fire panel, and also the detectors concerned will not go into alarm. This theory was initially put forward by Mr Daryl Knight in his report. However, it was not developed by the time the experts presented their joint report towards the end of the inquest. Wormald states that:

> *[t]he claim by DHS that there may have been reverse polarities in building 37 ... was rejected by the MFB in relation to the only instance cited by DHS and found no support from the Summary of the Fire Safety Experts ... or the McCumisky Report.*[57]

The MFB Reply to the State of Victoria's Submissions states that '*[a]s to paragraph 1.127 on page 202, Inspector Martin did not discover any detector wired in reverse polarity: see at T5105 and T5107. He did observe a change in the colour of wiring*'. [58]

The MFB submission is accepted.

(5) THE 'END OF LINE RESISTOR' THEORY

It was argued by the State of Victoria that the incorrect placement of the 'end of line resistor' is an explanation for the failure of the system. This theory is discussed in detail in the Findings in **4.1.9 General Integrity of the Fire Alarm System (1) Wiring.** See also the diagrams prepared by Wormald to explain the theory in Appendix 2.3 of the Findings.

4.1.6 SPRINKLER SYSTEM INSTALLATION: POTENTIAL TO AFFECT EXISTING ALARMS

At the time of the fire in Building 37, the installation of the sprinkler system was near to completion. Pipe work had been run through Unit 30 and into Unit 31. The sprinkler system has been estimated at being up to 70 per cent complete on 8 April 1996. In addition, installation of the sprinkler system involved drilling a series of holes to insert PVC pipe work. In some case these holes were drilled near to existing detectors (smoke or thermal). Testing conducted by the MFB during the inquest demonstrated that dust from the drilling would not have fouled the existing smoke detectors.

53 Wormald Submission, para. 3.26.

54 Exhibit 186 - see McCumisky's diagram of existing detectors in Building 37 after the fire.

55 Especially if, as has been argued, Wormald was running behind schedule.

56 See also the statement of Mr Harris, Exhibit 243, referred to in **(1) Interference during Installation and the 'Cut In' Theory.**

57 Wormald Reply, pp. 16-17, para. 5.8.

58 MFB Reply, p. 5, para. 11.

Any dust from drilling operations would not have affected the integrity of the thermal detectors because of the nature of their design and operation.

Interference with smoke detectors from sprinkler system installation is not considered likely.

4.1.7 AIRCONDITIONER INSTALLATION: POTENTIAL TO AFFECT EXISTING ALARMS

In its submission, Wormald explains the potential for the installation of airconditioners to trigger the fire alarm. Work on the installation of airconditioners commenced in the dayrooms of Flats A, B and E between 22 and 29 January 1996. During this period, on 24 January, a false alarm was recorded in Building 37, which necessitated evacuation. The airconditioner for Flat E was installed in a hole made in the north wall (to the lounge/kitchen). As this room had thermal detectors,[59] it is unlikely that dust would have triggered the alarm. Also there are no smoke detectors in the lounges of Flats A or B which may have resulted in a false alarm from renovation-related dust. Wormald suggests that a break in the wiring, caused by the installers, would have registered a fault at the main fire panel or, alternatively, if not fixed, the panel would not automatically reset.

As this did not occur, there is no probative value in the argument that the airconditioning installation caused a break in the wiring. In addition, circuit 39 operated on the night of the fire.

It is noted that Wormald does not seek to argue that the work on the airconditioners, occurring several days after it (Wormald) left the building, would have compromised the operation of the system. No compelling evidence was led to support the theory that there was a definite causal link between the airconditioner installation and the systems failure.

4.1.8 DAMAGE TO DETECTORS AND INTEGRITY OF FIRE SAFETY SYSTEMS

(1) RELEVANCE OF DAMAGE TO DETECTORS

The MFB Fire Investigation Unit identified a potential problem whereby either 'impact' damaged Hochiki thermal (model DCC-A) or smoke detectors (model SLK-A) may '*cause the detector to fail without a fault condition being registered at the alarm panel* ... [and] ... *will not register an alarm should a fire condition exist*'.[60] An exchange between Mr Bell and Mr Moore shows some current 'detector damage' at KRS:

> *Mr Bell: I also saw some detectors that had damaged heads. Did you notice any of those? I mean indented ones?*
>
> *Answer: I do recall seeing, again, one or two indented detectors.*[61]

Mr L. Neicho described what would happen in the event that a detector registered a fault:

> *[T]he circuit to which the fire detector was connected went into fault, a fault signal registered at the main alarm panel, the yellow fault light was illuminated and a fault buzzer sounded at the main alarm panel to indicate to staff in the administration building that a fault on the circuit had occurred and that they would call administration building that a fault on the circuit had occurred and that they would call out Jonkar to repair the fault. There was a button on the main panel which allowed the fault buzzer to be isolated.*[62]

59 Installed by Jonkar at Mr Vasan's instructions in November 1995.

60 Exhibit 235 - MFB letters dated 18 and 20 March 1997.

61 Transcript, p. 4131.

62 Exhibit 193, p. 8, para. 18.

Subsequent investigation by the MFB indicated that the problem applied to the same type of 'analogue addressable' as well as the conventional (hard-wired) smoke or thermal detectors. The problem was discovered in testing by the Fire Investigation Unit during the period 17 to 20 March 1997. Testing was being done by the Brigade to determine the state of the fire alarm system before the fire in Building 37 (in particular, Unit 31 and Flat E).

On discovering the problem, the Brigade wrote letters to KRS, Hochiki Fire Safety Products, Fire Protection Association of Australia, Australian Fire Authorities Council and Scientific Service Laboratories. In the first letter the MFB further puts:

> *[t]his condition can leave an area unprotected and as such, it has been recommended that, if these detectors are located in areas where damage may result, some form of intervention to ensure their integrity must occur. This may involve visual inspection on a regular basis, or some form of a barrier, such as a cage to prevent damage. However, where a cage is utilised it must be designed in such a manner so as not to affect the operation of the detector.*
>
> *The impact damage identified, in the case of the thermal detector, compromises the exposed thermistor being broken. In the case of the smoke detector, the light source is compromised, again effecting the operation of the detector.*[63]

Subsequent investigation resulted in further correspondence on the issue. The matter has not been thoroughly investigated with the manufacturer. Accordingly, it is not proposed to make any further comment dealing with the particular make of detector. However, the MFB tests indicate there may be a potential for impact damage to compromise the alarm. This matter is further developed in the next section of the Findings in (**2) Frequency of Resident or Unidentified Damage to Alarms at KRS.**

In addition the State of Victoria Submission recognises the importance of this issue when commenting:

> *[o]f the many lessons learnt in this inquest there is none more significant than that a conventional or addressable system of detectors is not necessarily fully operational despite a lack of fault signal or alarm at the main fire indicator panel (M.F.I.P.). In terms of a conventional smoke detector system there are a number of defects in the system which will not record a fault or alarm. Unless each and every detector is individually tested one can have no comfortable satisfaction that all detectors or indeed the system is working.*[64]

In its Submission, Wormald addresses the new system's ability to diagnose faults. Although acknowledging that not all analogue addressable systems have this capacity, the one installed at KRS can diagnose detector faults.[65]

(2) FREQUENCY OF RESIDENT OR UNIDENTIFIED DAMAGE TO ALARMS AT KRS

In its Submission, the MFB suggests that while *'the possibility of a detector being damaged by clients cannot be wholly excluded, it is a most unlikely scenario given that there were very few instances of such damage in building 37 in the time period examined by the inquest and none recent to the fire (see Appendix 3)'*.[66]

63 Exhibit 235 - MFB letters dated 18 and 20 March 1997.

64 State of Victoria Submission, p. 201, para. 1.121.

65 Wormald Submission, p. 29, para. 2.31 (emphasis added).

66 MFB Submission, p. 99, para. 174. See Appendix 2.6 of the Findings.

On the other hand, the Jonkar Reply urges that '*the court should not underestimate the capacity of the clients to deliberately damage the buildings and equipment*'.[67] It submits that '*[i]n addition there was particular motivation for the detector in bedroom 3 to have been damaged. Paul ... had a fascination with fire'*. This ignores the nature of Paul's disability. It is doubted that he would have the capacity to make the logical links that Jonkar seeks to make.

An examination of Appendix 3 to the MFB Submission 'Chronology of Known Detector Damage' reveals an extensive history of damaged detectors or BGAs throughout the complex from late 1991 until March 1996. However, there are only two instances of equipment damage in Building 37. These are in 1991 and 1993. In 1991 the note relates to the replacement of '*a faulty BGA in Unit 30/31'* and the 1993 event is '*a missing smoke detector head over a bed'*.

Although it appears that there were few instances of damage in Units 30/31, the possibility that the failure of the alarm system resulted from a damaged detector or detectors (resident-related or otherwise) cannot be excluded. However, it should also be noted that the delay in the activation of the alarm system is also indicative of more than one smoke detector failing. In the event that smoke detectors were installed in all of the bedrooms of Flat E, it would be expected that at least one would give a far earlier warning of the fire. For all smoke detectors to be damaged appears unlikely. But, against this, it cannot be determined as to whether doors to other bedrooms were closed during the early stages of fire development and, if so, the timing as to when they were opened by the residents during the fire.

(3) PAINTING

Painted detectors have the potential to compromise the effectiveness of the alarm system. The Submission of the State of Victoria argues that Jonkar should have identified the problem of painted detectors to KRS. In support of this proposition, it points to the evidence of Mr Moore that as many as 50 per cent of detectors at the complex were painted. However, it also argues that Flat E was not painted after September 1993.

Both Messrs L. Neicho and S. Moore were aware of the potential problem of painted detectors. On a question related to the Australian Standards, Mr Neicho replied that '*if they are painted, or dirty ... I know that it stops them working*'.[68] The significance of the lack of advice on this issue by Jonkar means that those working at KRS did not become aware of the potential to compromise safety. By way of example, Mr Vasan, the maintenance engineer, was not aware that over-painting of detectors caused problems.[69] However, he was aware of defects such as over-painting at KRS. He had noticed over-painting during maintenance walks around the building.[70]

Attached to the State of Victoria's Submission is an additional document signed by Mr Vasan in which Vasan refers to the installation of ten smoke detectors by S. Moore during September 1993 in the area now known as Flat E. He states that '*I have checked the records maintained by KRS and state from such investigations and my own personal knowledge that no further renovation or painting of that area has taken place since the installation of those 10 detectors'*.[71]

One question remains. The '*Fabric Survey & Building Utilisation Study: Part A Kew Cottages'* in its survey of Units 30/31 at page 2 comments under the heading '*Walls'– 'VG. All surfaces recently painted'*. That survey was evidently completed in May 1994. Further, significant work was undertaken in Unit 31 with the changes to Flats between May to October 1995. It is puzzling that the renovation work did not result in some painting.

67 Jonkar Submission in Reply, p. 23, para. 3.31.

68 Transcript, p. 4463.

69 Transcript, pp. 5825-5826.

70 Transcript, pp. 5825-5826.

71 State of Victoria Submissions, immediately following p. 246.

Jonkar's annual testing of the system occurred on 10 July 1995. It was undertaken by Mr Skye Neicho and did not disclose any faults for Units 30/31.[72]

(4) CONCLUSION

There is no conclusive evidence that painting affected the operation of the detectors in Flat E. It should be pointed out that, in view of other material, Mr Vasan's late statement does not operate to exclude this issue totally.

The potential for resident-related damage cannot be excluded.

4.1.9 GENERAL INTEGRITY OF THE FIRE ALARM SYSTEM

(1) WIRING

WIRING INTEGRITY: POTENTIAL FOR FAULTS

The issue of wiring was raised in a number of submissions. Principally, the focus was on the potential for damage to the existing wiring system by Wormald (or its subcontractors). Apparently, the new wiring for circuit 39 was installed in 1993. Thus the likelihood of the wiring affecting the integrity of the alarm system is not likely.

However, some caution must be expressed. It is noted that the Warrington Report raises some concern relating to the wiring running through old metal conduit. Also Daryl Knight's report found that much of the wiring of circuit 39 was old with perished installation '*which may have resulted in current earth leakages which could result in current levels which were insufficient to trigger an alarm'*.[73] In comparison, as is pointed out in the MFB Reply:

> *it is true that Mr McCumisky did not conduct a thorough examination of all of the wiring as he did not examine the old wiring that was in conduit. It was not necessary for him to do so as he conducted a continuity test of the wiring which showed that the wiring was continuous and operational (except of course in Flat E where it could not be tested). His examination of the wiring in building 37 was careful and appropriate. He was cross-examined on 18 February 1997 about his report and inspection of the wiring. It is clear from this evidence that Mr McCumisky's examination of the wiring properly enabled him to express an expert opinion as to the state of the wiring in that building.*[74]

As is put by Wormald, the fact that circuit 39 went into alarm shows that the wiring '*to the detector that went into alarm was continuous on the night of the fire'*.[75] Inspector Martin argues that the detector in alarm was a thermal at 39/22 (the bedroom of fire origin). If that was the case, then there was no fault with the wiring on the night of the fire. If 39/20 (a thermal in the corridor between the bathroom and kitchen) was the detector in alarm, then there may have been a wiring fault, which prevented the operation of 39/22. Wormald makes the point that:

> *if there was a fault in the wiring caused by Wormald, that fault should have shown as a fault light and operated a fault buzzer on the main Fire Indicator Panel (FIP) from 17 January 1996 onwards. It is possible to turn off the fault buzzer without repairing the fault but the fault light cannot be turned off. The evidence of Tregonning is that he inspected the main FIP as often as twice per day in the course of the upgrade and that he would have noticed a fault light on circuit 39 if there had been one. The purpose of these*

72 Exhibit 193 - 'Record of Maintenance & Test Report', No. 8451.

73 State of Victoria Submission, p. 122, para. 19.19; Exhibit 212.

74 MFB Reply, p. 2, para. 6.

75 Wormald Submission, p. 3, para. 1.2.

inspections was to check for faults or alarms on the FIP prior to isolation and de-isolation at the beginning and end of the day's work. His evidence is that there was no fault light on that circuit. That evidence was not challenged. The MFB attended the panel for alarms at Unit 30/31 on at least two occasions subsequent to 17 January 1996, (24/1/96 and 24/2/96). They would have reset circuit 39 and in the course of doing so noted a fault if there was one. There is no evidence that they noticed a fault.[76]

Although, if the '*end of line resistor'* is incorrectly placed, it is possible for a fault not to show on the FIP. The diagrams in Appendix 2.3 of the Findings show the possible positions of the end of line resistor. Wormald argue that there are three possibilities:

that it was correctly placed: that it was incorrectly placed and the circuit ran from East to West (Fig 2): and that it was incorrectly placed but the circuit ran from West to East (Fig 3).[77]

If it were correctly placed, any break in wiring would show on the FIP. If the circuit ran from East to West (see Appendix 2.3.2 of the Findings), then:

if the end of line resistor had been wrongly located (for example between 39/16 and 39/20) and the wiring was broken anywhere after the end of line resistor (e.g. between 39/20 and 39/18), no fault would show and none of the detectors beyond the break would have operated. This is because the FIP would wrongly read the presence of the end of line resistor as the end of the circuit and not read faults or alarms beyond that point.[78]

This scenario assumes that the detectors ran from 39/13 into Flat E rather than from 39/26 into Flat E. Thus, in the alternative, if the circuit ran from West to East (shown in Appendix 2.3.3 of the Findings):

and assuming the same position for the end of line detector (sic resistor) and the break in the wiring (i.e. the end of line resistor was wrongly located between 39/16 and 39/20, and the wiring break occurred between 39/20 and 39/18) – then a fault alarm would have shown. Further, all the detectors prior to the break (i.e. 17, 21, 25, 24, 23, 22, 19 and 18) could have gone into alarm.[79]

Wormald also suggested that the likely position of the end of line resistor:

was at 39/26 or 39/27, on the old section of detector wiring. Mr Les Neicho gave that location as his best recollection during the court visit held on 17/3/97. That area of the roof was destroyed in the fire or demolished shortly after. This is a plausible location given where the existing wiring entered the building at door 15 and what is known about the pattern of wiring in the building. There is no technical reason for Jonkar to have moved the pre-existing end of line resistor. It is probable that Jonkar did not move the end of line resistor when it installed the Flat E detectors but simply cut into the existing line of detectors at or about 39/13, looped out into Flat E, and then came hack into the existing line of detectors at 39/26.[80]

Further, Wormald suggested that the fact:

that circuit 39 went into alarm and the fact that the remaining wiring in the building was continuous support this conclusion. There is no evidence to the contrary. The Experts

76 Wormald Submission, p. 3, para. 1.3.

77 Wormald Submission, p. 4, para. 1.4.

78 Wormald Submission, p. 4, para. 1.6.

79 Wormald Submission, p. 4, para. 1.7.

80 Wormald Submission, pp. 4-5, para. 1.8.

> *Report (Ex 286 at point 2b) states that although a complete failure of the below ceiling detectors in Flat E was a possible scenario, there is no evidence to support it.*[81]

But, as Wormald stated '*[e]ven this conclusion has to be qualified: it may be that the detectors were not there, that they had been by-passed, that they had all been damaged, or that they had all been covered*'.[82] Finally, it was stated that:

> *[a]lternatively, it may mean that the wiring to the Flat E had been broken in circumstances where a wrongly located end of line resistor meant that a fault did not show. For the reasons outlined above – and as the experts must be taken to have agreed – there is no evidence for a break in the wiring.*[83]

Curiously, the State of Victoria does not recognise this concession when it argues that:

> *[d]espite the Wormald concession in its written submission, that the wiring to Flat E may have been broken in circumstances where a wrongly located end of line resistor would not have indicated a fault, it inexplicably misinterprets the opinion of the experts as being the wiring in Flat E was probably continuous. This was clearly not their position. At its highest the opinion of the experts was that they could not say either way. The State of Victoria submits this is another example of Wormald misconstruing the evidence.*[84]

Inspection by the court confirmed that much of the wiring for Flat E was under a skillion roof. This makes the possibility of accidental damage by Wormald, installation or airconditioning workers being less likely. The State of Victoria's contrary position has been considered.[85]

The State of Victoria argues that Wormald was responsible for identifying the correct position of the 'end of line resistor', and that '*it was incumbent on Wormald to identify any such deficiency by way of physically tracing the wiring on the first day*'[86] (see generally discussion in the next section, **Wormald's Responsibility**). There is no direct evidence that circuit 39 was incorrectly wired or damaged prior to the fire. Thus the possibility of the wiring integrity being compromised as a possible scenario to explain the failure is considered as being less likely.

WORMALD'S RESPONSIBILITY

The State of Victoria suggests that Wormald was responsible for effectively 'auditing' the wiring before the system was installed. The contract provided that the wiring for the detector system was to be re-used – as long as it was functional. The tender documents provided that re-using the wiring was an option B for the upgrade. This option saved about $50 000 on the contract. Wormald submitted that:

> *[t]he decision to re-use the existing wiring meant that those sections of the contract dealing with the standards applicable to the installation of new wiring did not apply. Where any new wiring had to be done as a result of the functional inadequacy of the old wiring, that would be charged to KRS as an additional expense.*[87]

81 Wormald Submission, p. 6, para. 1.13.

82 Wormald Submission, p. 6, para. 1.13.

83 Wormald Submission, p. 6, para. 1.13.

84 State of Victoria Submission in Reply, p. 526, para. 2.43.

85 State of Victoria Submission in Reply, p. 527, paras. 2.45-2.46.

86 State of Victoria Submission in Reply, p. 522, para. 2.34.

87 Wormald Submission, pp. 8-9, para. 1.22.

The Wormald Submission also examines Mr Taylor's understanding that the wiring would be examined to see whether it was suitable for continued use. It states that this was done in two ways *'by performing the commissioning test and by the continual monitoring by the FIP'*.[88] The commissioning tests:

> *show the wiring to be functional and leave the decision about when to replace the wiring (e.g. because there came to be an unacceptable level of faults in the wiring) in the hands of KRS.*[89]

On the practicality of undertaking a detailed assessment of the wiring, it is stated that:

> *[t]o have done a detailed assessment of wiring for which there were no plans, and which was in conduit and buried under insulation, would have added a layer of cost and difficulty that would have meant that it would have been little cheaper than installing new wiring.*[90]

It is clear that by taking option B (and using the existing wiring), DHS was attempting to minimise costs. Although re-wiring was the preferable long-term option, Wormald points to the fact that it was a decision for DHS to make. On the facts this argument makes sense.

Wormald commented on the second limb of its argument that continual monitoring of the system was achieved by the FIP. Wormald wrote to Mr Mitchell on 25 January 1996 stating *'currently all existing fire alarms in Unit 30/31 are still operational and have not altered in any form. All new equipment is inactive'*.[91] The State of Victoria effectively says that Wormald was not in a position to make this statement without checking every detector. Wormald suggests that it *'was entitled to assume that the existing fire detection system in Unit 30/31 was functional and being properly maintained by Jonkar, the existing maintenance contractor. As the Coroner discerned, (T 5126) Wormald's letter dated 25 January 1996 meant and was understood to have meant that the existing detection system had not been altered'*.[92]

Wormald points to the practical difficulties of testing every detector on the system in its area of daily work (as is effectively suggested by the State of Victoria in its Submission):

> *The assertion would mean that Wormald would have had to test every detector on every building after every day of work. There would have been a similar duty on the air-conditioning and insulation removalists who worked on the building subsequent to Wormald's departure. There was no such duty.*[93]

It is accepted that there was no such duty.

The Public Advocate suggested that Wormald should have notified DHS that there were incorrectly placed thermal detectors in Flat E. Wormald answered this allegation by stating that:

> *[m]ost of the bedrooms in Unit 30/31 had thermal detectors, as did most of the bedrooms at KRS. Wormald was entitled to assume that KRS knew this. There had been a fire safety audit and lack of smoke detectors was one of the reasons for the upgrade. Even if Wormald had known there were no smoke detectors in Flat E, to have told KRS that any particular Flat at KRS did not have smoke detectors in it would have been to state the obvious.*[94]

88 Wormald Submission, p. 9, para. 1.23.

89 Wormald Submission, p. 9, para. 1.23.

90 Wormald Submission, p. 9, para. 1.23.

91 Quoted in the State of Victoria Submission, p. 204, para. 1.132.

92 Wormald Reply, p. 17, para. 5.12.

93 Wormald Reply, p. 17, para. 5.11. See also State of Victoria Submission, pp. 204-205.

94 Wormald Reply, p. 23, para. 1.8.

In minutes of Site Meetings (from Meeting 1 on 14 November 1995 to Meeting 6 on 30 January 1996), Wormald warned that *'they cannot guarantee the integrity of the existing wiring or supply as wired drawings. They will test each existing circuit for alarm and fault condition prior to disconnection'*.[95] This statement clearly indicates Wormald's level of responsibility. The check on the wiring was made on the day of changeover when the system was connected. Evidence was given that:

> *because of the sophisticated functions of the new FlP and the analogue addressable detectors, it was far more efficient to check the functional integrity of the existing wiring on the day of changeover when the detectors were already connected to the old wiring. Any defects could then be remedied as part of the changeover process.*[96]

Practically, as Wormald submits, it *'believed and was entitled to believe that KRS knew of the general deficiencies of the system at KRS, that it had been the subject of an audit, and that these deficiencies were the reason for the upgrade'*.[97] Commonsense would suggest that this approach was reasonable.

It is not accepted that there was any agreement to check the wiring at any stage other than when the new system was connected. That was to be done with the assistance of the new addressable system, and in the circumstances, it was a reasonable work method.

(2) POSITIONING

The evidence of Mr S. Moore indicates the potential for failure to comply with Australian Standards on positioning of detectors, although it must be noted that the detectors probably remained in basically the same position in Flat E as installed by Moore in 1993. The concerns on positioning and compliance, which have already been broadly discussed, are again indicated in the following passage of evidence:

> *Question: Mr Moore, the dual testing that you do, and I repeat annual, requires you to look at the placement and condition of detectors in order to see that they comply with codes?*
>
> *Answer: Yes.*
>
> *Question: And in the case of the Kew Cottages contract, it was required that that be done in the case of all the detectors?*
>
> *Answer: Yes. ...*
>
> *Question: Yes. And it is a requirement of AS1670, isn't it, that a clear space of at least 300 mm radius shall be maintained from the detector, that is around the detector, in order just to be clear of anything for a radius of 300 mm?*
>
> *Answer: That's correct.*
>
> *Question: Also 1670 requires that 'the detectors shall not be installed closer than 400 mm to any air supply opening'?*
>
> *Answer: That's correct.*
>
> *Question: There is to be a space of at least 400 mm from such an opening to the detector?*
>
> *Answer: That's correct. ...*

95 Wormald Submission, p. 9, para. 1.24.

96 Wormald Submission, p. 10, para.,1.25.

97 Wormald Reply, p. 16, para. 5.7.

Question: I also noticed at least some detectors that were very close to fluorescent light housings. Did you notice those also?

Answer: Yes, I did.

Question: Certainly a distance not 300 mm from such a housing?

Answer: Yes, that's correct.

Question: Mr Moore, I also noticed when I was there a number of detectors that were placed very close to exhaust air supply openings. Do you know what I'm talking about?

Answer: Yes.

Question: Those holes with slats over them, circular slats over them. They were (indistinct) air supply opening, and I observed some detectors that were placed close to those? Did you see any of those, Mr Moore?

Answer: I remember observing one in that condition, yes. ...

Question: Standard 1670 requires that detectors shall not be installed closer to 400 mm from any air supply opening. I think I put that to you before?

Answer: You did, that's correct.

Question: Such a thing would register a fail against that standard, wouldn't it?

Answer: Yes, it would.

Question: Again, Mr Moore, in respect of the placement of detectors, I noticed some detectors that were placed near the edge of walls, that is at a point on the ceiling quite close to the wall?

Answer: Yes.

Question: Did you notice some of those also?

Answer: I do remember one, yes.

Question: At a distance not 300 mm from the corner?

Answer: That's correct.

Question: Being a non-complying detector, would you agree?

Answer: That's correct. ...

Question: That's a matter that renders that detector non-complying, I suggest to you?

Answer: Yes.

Question: Mr Moore, the standard also requires, and I refer here to the maintenance standard 1851, that you, check for any building alterations, changes in the environment, or utilisation of the protected area, which would require modifications of the system. That's 3.3J?

Answer: That's correct.

Question: I suggest to you that in the case of detectors to which other objects have been placed too close, for example the situation where a fluorescent light base has been placed too close to a detector, that standard requires you to check for that, and to see to its correction; do you agree with that?

Answer: That's correct.[98]

Thus it can be seen that there is potential for positioning and relationship to other equipment to affect the integrity of the system. There is no evidence of change of positioning or relationship to other equipment in Flat E after Moore's 1993 installation.

98 Transcript, p. 4131 et seq.

(3) NUMBER OF DETECTORS ON CIRCUITS

There were too many detectors installed on circuit 39. The Warrington Report commented that noncompliance with Australian Standards for detection systems included '*too many detectors on one circuit'*. The State of Victoria argued that Jonkar breached its professional obligations to DHS in that it allowed too many detectors to remain on one circuit. The Australian Standard (Section 2.6.1 AS 1670) puts the maximum number of detectors on a single activating facilitate at 40. It also noted that another Standard (3.3(1) of AS 1851.8) requires deficiencies to be brought to the attention of the owner of the facility. It appears that there were 55 detectors on circuit 39. Mr L. Neicho stated there were 15 extra detectors on the circuit,[99] and McClumisky confirmed too many detectors on the circuit.[100]

The State of Victoria also argued that:

> *[t]he excessive number of detectors Jonkar installed or allowed to remain on circuit 39 increased the risk of a systems failure by potentially rendering some detection devices on the system inoperative. Mr Knight noted in his statement that the consequence of an excessive number of detectors being installed on a circuit is that the balance of the circuit may be affected and the signal may not be sufficient to trigger an alarm (exhibit 212 p17 paragraph 5.4). Mr Lai was of the view that too many detectors on a circuit can cause the power capability of a circuit to be overdrawn and the movement of current to be impeded.*[101]

The MFB submitted in its Reply that an:

> *excessive number of detectors connected to a single activating facility which occurred in the present case would not have compromised the functioning of the detectors. The limit on the number of detectors is related to the need for the detection zone to be as small as reasonably possible, provided that the activating facility has sufficient power to activate the given number of detectors. In the present case that facility had the power to accommodate the detectors on loop 39 in building 37.*[102]

Thus it cannot be argued with any degree of certainty that too many detectors on circuit 39 would have compromised the system.

(4) CONCLUSION

It is unlikely that either wiring or the number of detectors on circuits could have affected the system on the night of the fire. There is no evidence of change of positioning of the detectors or of their relationship to other equipment in Flat E after Moore's 1993 installation.

4.1.10 FIRE ALARM PLANS FOR UNITS 30/31 AND THE 'JANUARY PLAN'

(1) RELEVANCE OF THE 'JANUARY PLAN' TO INDICATE THE STATE OF THE ALARMS

When Jonkar took over the maintenance of the fire detection system at KRS in 1991, there were no plans indicating detector position or type. There were no plans at KRS or within DHS files fully showing detector positions for Building 37 at the time (or shortly before) the fire. Plans indicating the positions of 85 smoke detectors installed at Kew by FFE were not provided to Jonkar.

99 Transcript, pp. 4467-4468.

100 Exhibit 164, pp. 1-3.

101 State of Victoria Submission, p. 237, para. 1.243; Mr Lai's evidence in Transcript, p. 3256.

102 MFB Reply, p. 5, para. 14; see, for example, Mr Hoskin's evidence in Transcript, pp. 4914-4915.

Jonkar presented a number of plans to show the detection systems for several of the units at KRS. There was concern expressed as to whether the detailed plan showing positions and types of detectors for Units 30/31 was in existence before the fire. This plan became known as the 'January Plan', as it was allegedly prepared by Mr Leslie Neicho (Jonkar) in January 1996.[103] Jonkar had also prepared a number of plans for the remaining buildings at the complex. It is noted that the plans prepared by Jonkar were not supplied to KRS before the fire.

The 'January Plan' was found to be inaccurate because it showed that 'smoke' detectors were fitted in all the bedrooms of Flat B, Unit 30. An inspection after the fire identified detectors in the bedrooms of Flat B as 'thermals'. It is significant that, in examination of the evidence on the state of the alarm system, counsel for the State of Victoria does not adequately examine the reason for the missing smoke detectors in Flat B. However, it is said that:

> *Jonkar personnel were unable to explain the non-existence of smoke detectors in locations 39/35, 39/36, 39/37 and 39/38 in Flat B. It is difficult to reconcile their claim that smoke detectors removed on a temporary basis were always reinstated.*[104]

It says that the parties have overstated the significance of the missing detectors in Flat B. Eventually, an examination of the evidence does not justify this remark.

(2) EVIDENCE ON THE 'JANUARY PLAN'

The issue of whether or not the 'January Plan' existed before the fire involves an examination of motive. The MFB suggests the motive when the plan was prepared after the fire by Mr L. Neicho as being '*in order to establish that a smoke detector was in situ at that time in Paul's bedroom when he well knew that this was not or might not have been the case'*.[105] Mr L. Neicho described his preparation of the January Plan thus:

> *I prepared the January plan after receiving Stephen Moore's handwritten plan and details of the works performed in unit 30/31 since December 1993. I believe that the January plan accurately sets out the location of the smoke and thermal detectors in the flat E area of unit 30/31 as at 3 January 1996. All of the detectors used were Hochiki detectors.*[106]

At the highest, Mr L. Neicho considered that the 'January Plan' was a document prepared by him only after seeking information from his employees and records.

A part-time employee of Jonkar, Mrs Norma Zenere, prepared plans of the fire detection systems at KRS. About the time that Jonkar took over the maintenance contract, a booklet of handwritten plans was prepared by two of Jonkar's staff. Zenere prepared more detailed plans from these documents. A plan was prepared of Units 30/31 (before renovations) from these handwritten plans. Apparently, Zenere drew the plan of layout of the rooms of Units 30/31 (after renovations) in November or December 1995. Zenere stated that:

> *I have inspected the January plan. In November or December 1995, I prepared a tracing of the layout of the rooms in Unit 30/31 at Kew Cottages. This tracing is contained in the January plan I based my tracing on a plan of the layout of the rooms in unit 30/31. I do not recall where the plan of the layout of the rooms in unit 30/31 which I based my tracing on came from. I did not have any other involvement in the preparation of the January plan.*[107]

103 Exhibit 193. For 'January Plan', see L. Neicho statement - LJN 10.

104 State of Victoria Submission in Reply, p. 462, para. 1.15.

105 MFB Submission, p. 61, para. 128(iv).

106 Exhibit 193, p. 8, para. 17.

107 Exhibit 209, para. 3.

Mrs Zenere was on leave from December to mid-February 1996.

Mr L. Neicho did not generally inspect the work done by his employees at KRS. Neicho stated that in about September 1993 he was instructed to install smoke detectors in what he knew to '*be the flat E area of unit 30/31'*. He also indicated that he was '*not aware that unit 30/31 had been divided into flats until after the fire'*.[108] Apparently, Mr Stephen Moore replaced a smoke detector with a thermal in position 39/21 (Flat E) on the January Plan in June 1995. The '*smoke detector was replaced with a Hochiki Type A thermal detector due to renovations that were taking place in the flat E area involving the conversion of a bedroom to a bathroom'*. Evidently, until this work, Mr L. Neicho *'was not aware that renovations were taking place in unit 30/31'*.[109]

Mr Skye Neicho, a fire protection technician, performed the annual maintenance tests for the fire protection system for the years ending June 1994, 1995 and from July to December 1995. He commented that, during the testing process, not many defective smoke/thermal detectors were located as:

> *if a detector becomes faulty, it usually generates a fault signal at the main alarm panel which results in Jonkar being called out to replace or repair the detector.*[110]

Mr S. Neicho first saw the 'January Plan' after the fire. Moore believed that '*that the January Plan accurately sets out the location of the smoke and thermal detectors in the Flat E area ... as at 3 January 1996'*.[111] On 24 May 1995, Mr S. Neicho attended Building 37 responding to a false alarm on circuit 39. Because of renovations to Flat B, smoke detectors had filled with dust. They were replaced by thermals at positions 39/35 and 39/39 on the January Plan. Until attending for this work, S. Neicho was unaware of the renovations and did '*not become aware until after the fire that unit 30/31 had been divided up into flats A and E'*.[112] On 26 June 1995, S. Neicho again attended at Flat B and replaced a smoke detector that was full of dust due to renovation works. It was replaced with a thermal. On 23 June 1995, Mr S. Neicho attended Building 37 with Moore for a false alarm in Flat E. The alarm emanated from a smoke detector in a bedroom that was being converted into a bathroom. Evidently, concrete dust had caused the detector to go into alarm. The next day the smoke detector was changed to a thermal.

Mr Moore informed L.Neicho that he was requested to check whether '*the fire detectors in the newly renovated flat E area "conformed with Code".*' [113] When Moore attended Unit 30/31 (on 2 November 1995) and '*found that there were two smoke detectors in the kitchen area'* of Flat E, they were replaced with Hochiki thermals. Evidently, these replacements occurred in positions 39/18 and 39/19 on the January Plan. L. Neicho was also told by Messrs Moore and S. Neicho that they both attended (with Mr Travis Cox) for a false alarm on circuit 39. Apparently, the three servicemen:

> *located a smoke detector in the corridor in the Flat E area at position 39/20 on the January plan which had been activated by steam coming from the shower* ... [and] ... *replaced the smoke detector with a thermal detector.*[114]

Messrs S. Neicho and Moore confirmed this replacement. Mr Cox could not recall the event.

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108 Exhibit 193, p. 11, para. 29.

109 Exhibit 193, pp. 12-13, para. 35.

110 Exhibit 181, para. 3.

111 Exhibit 185, para. 18.

112 Exhibit 181, para. 7.

113 See Exhibit 167 - AUSTRALIAN STANDARDS - AS 1670-1995.

114 Exhibit 193, p. 13, para. 37 (see Jonkar invoice 001834 dated 3 January 1996).

After the fire, Inspector Martin instructed Leading Fire Fighter Trevor Pillinger (FIU) to obtain from Jonkar all plans and diagrams showing the layout of Unit 30/31 (in particular, Flat E). Pillinger informed Martin that he telephoned Mr L. Neicho who agreed to send the plans. Later the same day – 23 April 1996 – Martin told Qualified Fire Fighter Nick Petersen (FIU) to attend at Jonkar to collect the plans. Petersen contacted L. Neicho who agreed to deliver the plans the next day. Mr L. Neicho delivered the plans to the MFB on 24 April 1996. Martin viewed all the delivered documents and commented:

> *The plan of Unit 30/31 shows the fire protection equipment in the Flat A, B, C and D areas and has some handwritten alterations including some incomplete alterations in the Flat E area. The plan did not show the layout of Flat E. This was of little use to me as I knew what fire protection equipment existed in the other flats. The purpose of the exercise was to ascertain the state of Flat E.*[115]

It is '*for that reason'*, Martin opines, that the 'January Plan' was not included with the documents delivered by L. Neicho. The remainder of Martin's statement provides detail on the handling of the documents received from Neicho on 24 April. Martin does say that he did not see the 'January Plan' until he received a copy from the Brigade's solicitors in late December 1996.

On 23 April, Leading Fire Fighter Trevor Pillinger contacted Mr L. Neicho by telephone (as instructed by Martin), and noted the fact in his diary. He requested *'all plans of the fire alarm system at Unit 30/31, both past and proposed'*. Pillinger also asked for service documents. He stated that *'Mr Neicho told me that Wormald were taking over the contract for Kew. I explained that we were interested in the system as it existed at the time of the fire'*.[116] Mr Pillinger faxed a request to L. Neicho the same day. The request stated: '*... could you please indicate the fittings that were installed, what they were and any proposed fittings*'.[117]

In his statement Fire Fighter Nicholas Petersen (FIU) confirmed the discussion with Martin and his contact with L. Neicho. He met Neicho at the FIU offices on the morning of 24 April. Petersen looked through the documents as he was:

> *particularly interested in plans or information about 30/31. This would assist us in determining the detection and suppression system in 31, and in particular, Flat E. I can recall seeing the Plan Drawing Number S127/6 which shows the Units 30/31 with various hand-drawn markings showing Flat B in Unit 30 and a line showing the outline of the extension for Flat E.*[118]

Mr Petersen also related that:

> *Mr Neicho went through the material he had supplied with me. Whilst we were looking at S12716, he told me that one of his technicians had been out to Flat E and changed two smoke detectors to thermal detectors in the bathroom area. His technicians had been out on a separate occasion and changed two smoke detectors to thermal detectors in the kitchen area. He told me that this was because the detectors had been set off by steam and cooking.*[119]

Further, Petersen said that Mr L. Neicho:

> *told me that one of his technicians had changed a detector in a bedroom of Flat E. He told me that the technician could not recall if the detector was a smoke or thermal. I asked him*

115 Exhibit 245, pp. 1-2, para. 6.

116 Exhibit 244, para. 3.

117 Exhibit 244, paras. 3, 5, attachment TP2.

118 Exhibit 246, para. 4.

119 Exhibit 246, para. 5.

which bedroom it was in, and he told me that the technician had told him that it was a bedroom on the north wall of Flat E but the technician could not recall which it was. I asked him which detectors he thought were in the bedrooms of Flat E and he could not recall.[120]

Significantly, Mr Petersen then asked L. Neicho *'if he had any other plans showing the renovated layout of this area, meaning Flat E. He told me that this drawing S127/6 was all that he had'*.[121]

There was further discussion between Messrs Petersen and Neicho about the invoices for the work in Flat E. Neicho showed Petersen the 2 November 1995 invoice (changing two smoke detectors for thermals in the kitchen). Also discussed was the work on 3 January 1996 replacing a smoke detector in the corridor with a thermal because of steam from the bathroom. Neicho showed Petersen invoices for 23 and 24 June 1995, and explained *'that his technician could not change a detector until the next day because the concrete floor was wet'*.[122]

Mr Petersen stated that he had not seen the 'January Plan' until shown it on 5 March 1997. Petersen further stated that he *'would have recalled seeing such a plan which showed the detection system in Flat E'*.[123] Earlier, Fire Investigators had requested carers at Kew to draw the detection system in Flat E because no plans were available.

In its Submission, Jonkar summarises Mr Neicho's position:

Without Mr Peterson's completely unsatisfactory evidence the position is as follows: Mr Neicho produced a bundle of plans to the MFB on 24 April 1996. He believes that the January plan was probably among those plans. No detailed conversation with the recipient of the plans ensued. Mr Neicho was never contacted again by the MFB in relation to the fire.[124]

In view of the evidence of Mr L. Neicho about the conversation in the Transcript at pp. 5575-5576, this submission is puzzling. Mr Petersen gave evidence of the conversation with L. Neicho. Petersen stated that he *'specifically pointed to that hand-drawn box and said have you got any other plan on this area? We need this.'* and he said, *'No, sorry we don't.'*.[125] Neicho told Petersen *'that that was the only plan and information he had on the area'*.[126] When giving evidence, Mr L. Neicho said:

Mr Bell: Then he said to you, "Mr Neicho, have you got any plans setting out what the fire system in Flat E on the day of the fire"?

Answer: I remember – I remember him asking – is that fresh water.

Question: Are you okay, Mr Neicho?

Answer: I am trying to remember exactly what you said.

Question: That is all right; I will repeat the question; I am suggesting to you that Mr Peterson said, " Mr Neicho, have you got any plans showing what was in Flat E on the day of the fire"? —

Answer: I said, yes, I have, and I said, I have picked all these up. I will go back and get others. If I have mixed ..." [Mr Neicho was then excused as he was apparently ill].[127]

120 Exhibit 246, para. 6.

121 Exhibit 246, para. 7.

122 Exhibit 246, para. 8.

123 Exhibit 246, para. 12.

124 Jonkar Reply, p. 11, para. 2.21.

125 Transcript, p. 5562.

126 Transcript, p. 5536.

127 Transcript, pp. 5575-5576.

Mr Petersen's evidence is accepted as being accurate and truthful. There was a detailed conversation, and the January Plan was not given to the MFB at this meeting. Mr Neicho's explanation is rejected. In making that decision, the apparent effect of Mr Neicho's health has been taken into consideration.[128]

Mr L. Neicho gave evidence that it probably would not have taken as long as three or four hours to prepare the plan.[129] Yet a study of the plan shows that it required some detail and effort to prepare without drawing mistakes or smudges. It would have taken some time to marshal the information for insertion in the plan. In this context, it is suggested on Mr Neicho's behalf:

> *Uncertainty in relation to precisely how the January plan was prepared is evidence of him deliberately trying to avoid committing himself to a clear answer as to what he had done to produce the January plan. On the contrary, it is consistent with a man who genuinely did not remember preparing the January plan some fourteen or fifteen months prior to giving evidence about it. Mr Neicho states that plans were made up from time to time on an ongoing basis. Therefore, the preparation of the January plan was not a particularly remarkable task. The Court would have more reason to suspect a fabrication if Mr Neicho's evidence on the preparation of the January plan was word perfect. If Mr Neicho was to engage in a fraudulent fabrication of the plan and a persistent perjury, one would at least expect that he would have prepared a comprehensive version of how he prepared that plan.*[130]

It is difficult to accept that Mr L.Neicho would not remember having prepared the plan himself in 'January', some three months before the fire. It would have taken him some time to draw in the detail (at the very least using the stencil for the circles). That Plan detailed the very flat where the fire occurred.

There is another issue that gives rise to concern. On 13 May 1996, Mr L.Neicho wrote to Vasan:

> *Re: Invoices numbered 001392 and 001393 dated 29/12/95 Fire Alarms System*
>
> *As requested we hereby submit details of work carried out relating to the above invoices.*
>
> *For the supply and installation, including additional wiring, of 10 photo optical smoke detectors and two additional type A thermal detectors to the refurbished area in Unit 3I.*
>
> *We enclose a hand drawn sketch produced on site by workers.*[131]

The hand drawn sketch was prepared by Mr Moore when he installed ten smoke detectors in the old area in 1993. This was both a reminder and an opportunity for L. Neicho to enclose the 'January Plan'.

Jonkar's submission on the use of the stencil is worthy of comment:

> *The Parents Association assert that "it is curious that Neicho claimed that he could not use the small stencil". Mr Neicho clearly explains that the reason for this is the small size of the 's'. The Court expressed a preliminary view that the "s" were "all about the same size" (T.5888 L.7). It is respectfully submitted that, on a careful examination the sizes do indeed vary. More importantly, the shapes vary. If, contrary to Mr Neicho's evidence, a*

128 See also Jonkar Reply, pp. 7-8, beginning of para. 2.10.

129 Transcript, p. 5880.

130 Jonkar Reply, p. 7, para. 2.8.

131 See Parents' Association Submission, pp. 101-102, para. 289.

stencil was used for the "s", the shape of the "s" would not vary. For example, the loop on the lower part of the "s" at detector 39/37 is different to 39/22, which is in turn different to 39/17.[132]

Without the correct size 'Rotring' stencil, pen and nib being used to demonstrate the proposition, this explanation is rejected.

Mr L. Neicho's evidence on how he drew the 'January Plan' varied considerably. It was less than impressive. It was argued by counsel for Jonkar that the evidence of both Zenere and Moore was supportive of the fact that the 'January Plan' existed prior to the fire. Both gave evidence that they saw the 'January Plan' before the fire. It was suggested that this evidence should be accepted. Nevertheless, the principal evidence from Jonkar on the existence of the 'January Plan' was by Mr L. Neicho and his evidence was not impressive.

Mr L. Neicho was informed by Moore that, on 2 November 1995, he, in other areas of Building 37 *'used one of the smoke detectors to replace a thermal detector in position 39/4 in the Flat D area'*.[133] Mr Taylor commented on Jonkar's maintenance and the plans:

I had no reason to be dissatisfied with their performance but there was no plan of where smoke detectors were located in Flat E at the time of the fire. It was my general understanding that smoke detectors were installed in all renovated bedrooms.[134]

Further, Mr Taylor commented that:

I understood that hardwired smoke detectors were placed in all renovated areas save where Jonkar Industries considered it inappropriate to install a smoke detector. I would have expected that in the event that a smoke detector were replaced in a unit it would follow discussions between Jonkar Industries and Mr Vasan based upon the advice and expertise of Jonkar Industries.[135]

There is another difficulty with the provenance of the 'January Plan.' The completed 'MFB Report' was delivered to the Coroner's Office with a covering letter on 30 August 1996. That report contains a number of plan drawings of Units 30/31 and Flat E. The report was made available for the relevant parties to view or copy sometime after that date. A comparison of the drawings in the MFB Report[136] with the 'January Plan' shows some striking similarities. For example, in the detail of the dotted lines indicating the edge of the decking on the northern side of the building, both plans are similar. Those lines do not appear to be drawn in any other plan in evidence. Apparently, the MFB Report became accessible to the parties via the Coroner's Office after 30 August 1996. It is noted that the 'January Plan' first surfaced in documents in the possession of DHS's instructing solicitors on 12 July 1996.[137]

Whether there are other earlier plans from which the 'January Plan' was taken cannot be answered.

(3) CONCLUSION ON THE 'JANUARY PLAN'

The Jonkar Submission argued that *'[t]here is simply no conclusive evidence that the January plan was prepared after the fire. In the absence of very strong evidence that the January plan was prepared*

132 Jonkar Reply, p. 7, para. 2.9.

133 Exhibit 193, p. 13, para. 36 (see Jonkar invoice 001774).

134 Exhibit 159, p. 12.

135 Exhibit 159, p. 12.

136 See drawings in the MFB Report, pp. 5, 140.

137 Exhibit 202 - 'Copy of original plans given to Mr V. Harcourt on 12/7/96 including January Plan'.

after the fire the Court should not disbelieve the oath of three persons'. On the standard of proof, the Submission states:

> *The ordinary standard of proof required of a party who bears the onus in civil litigation in this country is proof on the balance of probabilities. That remains so even where the matter to be proved involves criminal conduct or fraud. On the other hand, the strength of the evidence necessary to establish a fact or facts on the balance of probabilities may vary according to the nature of what it is sought to prove. Thus, authoritative statements have often been made to the effect that clear or cogent or strict proof is necessary "where so serious a matter as fraud is to be found". Statements to that effect should not, however, be understood as being directed to the standard of proof. Rather, they should be understood as merely reflecting a conventional perception that members of our society do not ordinarily engage in fraudulent or criminal conduct and a judicial approach that a Court should not lightly make a finding, that, on the balance of probabilities, a party to civil litigation has been guilty of such conduct.' Neat Holdings Pty. Ltd. v. Karajan (1992) 110 ALR.*[138]

This submission also puts that '*[t]he allegation that Mr Neicho fabricated the January plan amounts to an allegation of fraud against Mr Neicho and repeated and persistent perjury against Messrs Neicho, Moore and Zenere'*. Proof that the plan was a fabrication must be '*clear, cogent and exact and when considering such proof, weight must be given to the presumption of innocence (Cunning Smith & Co. Ltd. v. Western Farmers Co-operative [1979] VR 129 at 147; Anderson v. Blashki [1993] 2 VR 89 at 96).*'[139]

One of the unexplained issues with the 'January Plan' is that Mr L. Neicho, who inserted the detail on the plan a short time before the fire in January 1996, did not present it to the MFB during the first meeting in April. Because of the careful detail required in the work, it is difficult to understand how he would have forgotten the plan when discussing the layout of the alarm system with Petersen.

Nevertheless, while there are significant, and unexplained, concerns about whether the 'January Plan' actually existed prior to the fire, because of the required standard of proof, it cannot be said that the plan did not exist. Equally, it cannot be said conclusively that it did. However, what can be said about the 'January Plan' is that it is unreliable. It does not correctly describe the position of the detector system as at the time of the fire. It has been found to be inaccurate in a number of crucial areas. For example, it places smoke detectors in all the bedrooms of Flat B. They were all thermal detectors (see Appendix 2.4 'The McCumisky Plan').

Accordingly, as the 'January Plan' is unreliable, it is necessary to look for other evidence to discover what detector system existed in Flat E on the night of the fire.

4.1.11 EVIDENCE OF MAINTENANCE CONTRACTOR ON THE STATE OF THE SYSTEM

The very nature of Jonkar's approach to compliance with its maintenance contract does not inspire any confidence in the operation of the fire detection system. The question of confidence in the operation of the system is different from the question as to what was the state of the system.

A maintenance work practice had been undertaken at KRS by Jonkar that must initially give rise to considerable doubt about the state of the system on the night of the fire. Generally, whenever there was a false alarm, the offending smoke detector was changed for a thermal. This work practice had occurred for a number of years. The Wormald Submission comments:

138 Jonkar Submission, p. 17, para. F2.

139 Jonkar Submission, p. 22, para. F7.

It is consistent with the general practices adopted with respect to replacing smoke detectors at KRS where there was a problem of false alarms for the smoke detector to have been replaced by a spare thermal detector. Mr Neicho said he would sometimes not charge and not document this sort of service. It seems that he would have spare thermal detectors in his van. He claimed there had been a similar practice of removing smoke detectors during renovations and then replacing them after that work was complete without documenting the work, although it must be doubted whether such replacements took place.[140]

To illustrate the point, Wormald remarked:

On 3/1/96, Moore replaced the smoke detector in the corridor outside the bathroom with a thermal detector because steam from the bathroom had caused a false alarm. This replacement is symptomatic of the practice that had developed at KRS of reducing such false alarms by replacing smoke detectors with thermal detectors rather than blocking off the window from where steam was coming, or installing proper exhaust fans in bathrooms.[141]

The Villamanta Legal Service also commented generally on this issue in these terms:

Jonkar Industries gave evidence that the changes of detector when renovations are in progress are temporary. When the renovations cease the smoke detectors are restored where such restoration is appropriate to the use of the building. However no dockets were tendered in evidence to support this claim. Further Kew management was not in the habit of informing Jonkar of its intention to renovate, and, VLS submits, was unlikely to advise when the work had been completed.[142]

As KRS did not advise the maintenance contractor as to when renovations were complete, it would seem unlikely that Jonkar would know when it was suitable to re-instate the smoke detectors. As there were a number of Jonkar staff from time to time working at the complex, an additional question must be posed: would each member of staff remember when and where the individual thermals had to be replaced? It must be remembered too that Jonkar had regularly to service false alarms for a number of buildings at the complex other than Building 37, and its documentation left a lot to be desired. For much of this time, there were no plans for Building 37 – other than Moore's 1993 hand drawn plan of the installation of ten detectors in the area now known as Flat E.

Certainly, it is difficult to understand why, over the years, there were no instances of documented changeover from thermals back to smoke detectors and there was no charging for the additional work. Flat B is telling in this regard. There is no explanation by Jonkar as to how, when and why smoke detectors are not in situ in each of the three bedrooms of this flat after the fire. If the practice was to change thermals back to smoke detectors after temporarily addressing a false alarm problem, then smoke detectors should be in Flat B bedrooms. The evidence of Mr L. Neicho inspires little confidence in this area:

Mr Neicho: They were never invoiced. Normal thing what we would do, we would go back. We were on site quite a lot and we just – as we would pass – if work is finished – we would replace them.[143]

Further, it was stated in evidence:

Mr Neicho: If there's renovations on, and there's not – and we don't get involved with extension work, I've been on site myself: pulled the detector out put a thermal in, when

140 Wormald Submission, p. 23, para. 2.16.

141 Wormald Submission, p. 27, para. 2.25.

142 Villamanta Legal Service Submission, pp. 43-44, para. 6.7.5.

143 Transcript, p. 4423.

the builder's finished we've gone back and its been to my mind whoever goes back, whack a smoke in. It's charged in that first bit – a bit stupid, I suppose.[144]

With the number of call outs to KRS and the number of Jonkar employees attending for a variety of jobs in differing units, it is difficult to accept that this work practice had the required degree of certainty that fire safety would require.

The evidence of installation of smoke detectors in Building 37 from 1993 shows that there should have been 20 detectors. Ignoring the area destroyed by the fire, there should have been 12 smoke detectors (five installed by FFE, five in Flat B, one at 39/4 and one at 39/21). After the fire, there were only three smoke detectors in the undamaged area. These detectors were at 39/4, 39/35 and 39/17; it is noted that 39/17, in Flat C, was not worked on. The State of Victoria argues in its Reply that the discovery of smoke detectors at 39/4 and 39/17:

is of particular significance because Mr Moore had attended unit 31 several months prior to the fire namely 2 November 1995 to confirm that all Flat E smoke detectors conformed with code and attended again on 3 January 1996 to attend a smoke detector in alarm in Flat E. In all areas of Unit 31 not destroyed by fire the MFB were able to support Mr Moore's evidence as to the location of smoke detectors.[145]

The State of Victoria also argues that the:

Wormald submission invites the Coroner to draw inferences and proceed by way of a "process of exclusion" to arrive at a conclusion that there were no smoke detectors in Flat E after 3 January 1996. The State of Victoria submits there is no reasonable basis to justify such an inference.[146]

Unfortunately, the total lack of an explanation for the missing smoke detectors in Flat B, the incorrect 'January Plan', the significant breach of Australian Standards and the regular replacement of smoke detectors with thermals all add to concerns. There is no confidence in Jonkar's evidence on the state of the system. There can be no confidence that Jonkar re-instated the detectors once replaced with thermals. In addition, the uncertainty of evidence of Skye Neicho and Moore on the state of the system adds to the evidentiary problems. KRS's management evidence is not definite enough to boost Jonkar's evidence. Thus a process of elimination in looking at Building 37 is a reasonable method of determining the state of the system.

It is noted that Mr Taylor was aware that smoke detectors were being replaced with thermals. He had a continuing '*lack of faith in the ageing system*'. It was said in evidence:

Mr Osborn: But you didn't ask Mr Stewart to investigate whether the causes of the false alarms could be attributed to particular problems with the equipment or its maintenance?

Answer: No, I never did, no.

Question: Did you know that Jonkar's had replaced some smoke detectors with thermal detectors?

Answer: Yes.

Question: Was that something that you discussed with Mr Stewart?

Answer: No, we didn't.

Question: Or with anyone who had expertise in fire protection?

Answer: No.[147]

144 Transcript, p. 4425.

145 State of Victoria Submission in Reply, pp. 545-546, para. 2.87.

146 State of Victoria Submission in Reply, pp. 545-546, para. 2.87.

147 Transcript, p. 5362.

The problem with Flat B can be seen in the following exchanges. Mr L. Neicho gave evidence that he was extremely reluctant to change smoke detectors for thermal detectors. Yet it was a regular part of the maintenance work at KRS. He also answered:

> *Question: As far as you're concerned, you didn't change smoke detectors for thermal detectors? In bedrooms?*
>
> *Answer: In bedrooms, no.*
>
> *Question: And you say that for Flat B as well as Flat E?*
>
> *Answer: That's correct.*[148]

When further discussing Flat B and the fact that thermals were in position when the plans indicate the presence of smoke detectors, Mr L. Neicho replies in evidence:

> *MrHennessy: Given that as a fact, does that cause you to challenge your own assumption that what are indicated as smoke detectors in Flat E might in fact have been thermal detectors?*
>
> *Answer: No. I still – I still think there should have been smokes in Flat B. I know there was one there when we did the inspection.*[149]

If the last statement of Mr Neicho is correct, at some stage during the inspection Jonkar discovered that Flat B was short some of its smoke detectors in the bedrooms. Apparently, it neither advised KRS nor did it seek to rectify the position. Clearly, as the maintenance contractor, it would have been in a position to fix the problem and had a responsibility to do so. This was its job. Accordingly, it is unlikely that there was a smoke detector in a bedroom when the inspection was done.

The State of Victoria suggests that '*in view of the evidence of Jonkar personnel that smoke detectors were reinstated, one ought to be slow to draw an inference that smoke detectors were not reinstated by reason of lack of documentation*'.[150] In view of Mr L. Neicho's evidence, this and the following submission is not as persuasive:

> *on this critical issue of reinstating smoke detectors in circumstances where they had been temporarily replaced by thermal detectors is that not only did all Jonkar witnesses questioned on this issue give similar evidence, but the observation of the only non-Jonkar witness, Mr Vasan, confirmed the presence of detectors in locations where they ought to be if they had been reinstated.*[151]

Mr Vasan was not in a position to observe all the alleged 're-instatements'. Flat B leaves a problem for this submission – it is not explained.

The State of Victoria's examination of the remaining state of the detector system in Unit 31 as being 'two smoke detectors only'[152] ignores the broader state of the system that should have been in Building 37 before the fire. In spite of Jonkar's 'January Plan', the whole building did not have that complement of smoke detector layout that the documented history would suggest.

The evidence of Jonkar staff places four smoke detectors in Flat E on the night of the fire. There was one in each of the three bedrooms. One was in the corridor between bedrooms 2 and 4.[153]

148 Transcript, p. 4602.

149 Transcript, p. 4603 (emphasis added).

150 State of Victoria Submission in Reply, pp. 461-462, para. 1.14.

151 State of Victoria Submission in Reply, p. 462, para. 1.17.

152 State of Victoria Submission in Reply, pp. 550-551, para. 2.98.

153 Exhibit 193 'LJN10'.

All the fire experts are of the view that none of the bedroom smoke detectors operated on the night of the fire as they '*would be expected to occur in approximately 150 seconds'* from the ignition of the fire.[154] An examination of all the other theories (with the exception of the possibility of detector damage) does not explain the failure. The MFB states:

> *If it cannot be accepted with sufficient assurance that a thermal detector in compartment of fire origin gave the alarm, it can be accepted with a high degree of assurance that the detector in that room was not a functioning smoke detector. Equally it can be concluded with a high degree of assurance that no smoke detector in Flat E activated the alarm.*[155]

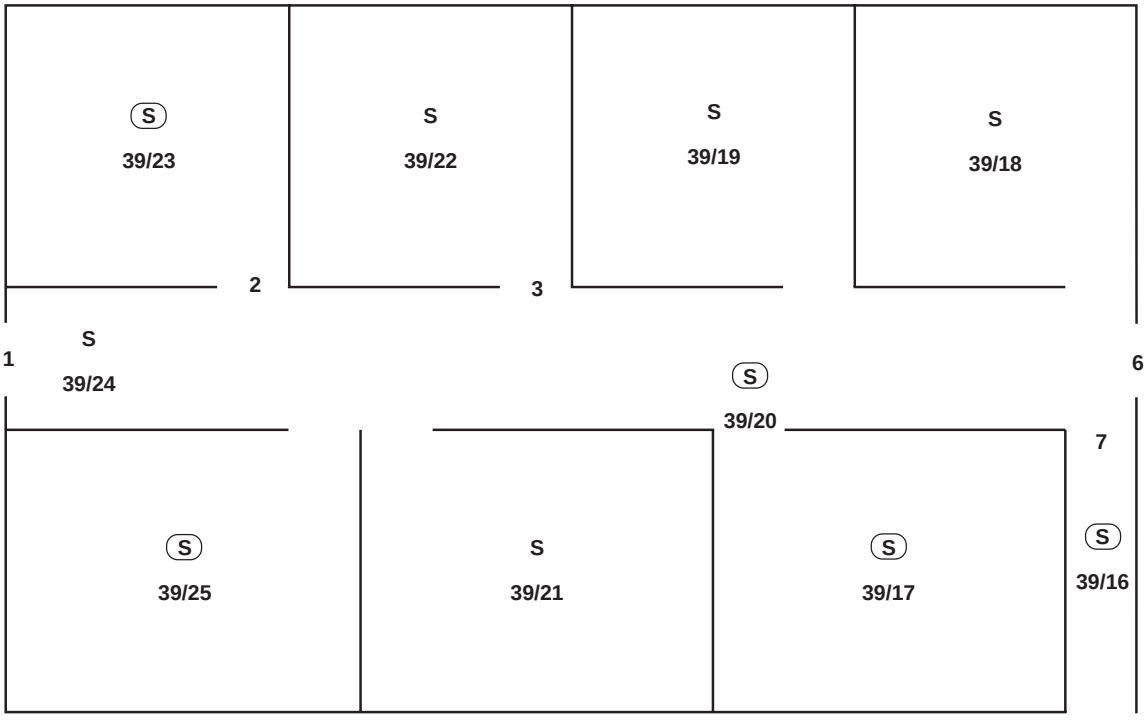
A number of parties put forward a single hypothesis as to why the smoke detection system in Flat E did not work.[156] The allegation was that the four smoke detectors were not in position at the time of the fire. The State of Victoria has a different view: it, with Jonkar, principally argues that the problem lies with Wormald's work.

In September 1993 Mr Moore installed ten smoke detectors in bedrooms and corridors that were to become Flat E. The Villamanta Legal Service prepared the following diagram from Mr Moore's hand written plan to illustrate the positioning of the detectors. The design of the building at the time of the fire was different.

Smoke detectors installed before the 1995 renovations (installed in September 1993 by Mr S Moore).

KEY FOR PLAN

39 Circuit number	**24** Detector number on circuit	**S/(S)** Smoke detector



154 Exhibit 222, para. 7 (emphasis added).

155 MFB Submission, p. 62, para. 129.

156 See, for example, Submissions of the Parents' Association, Public Advocate, Villamanta Legal Service and the MFB.

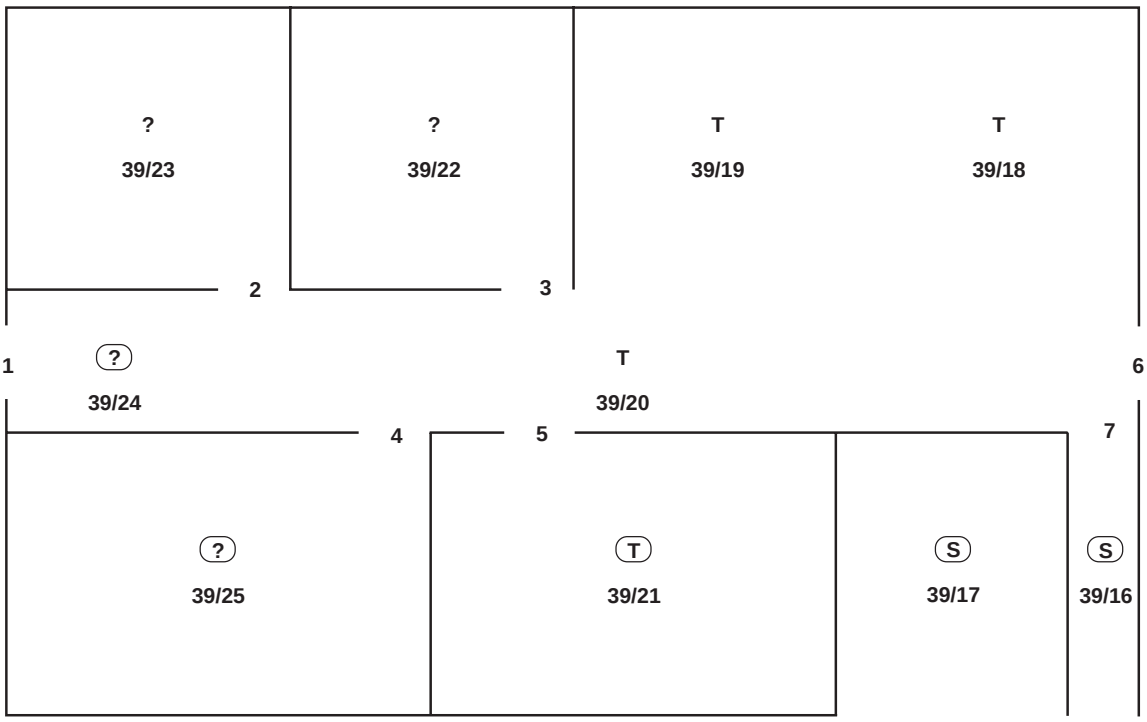
Following the 1995 renovations, this area became Flat E. The smoke detector at '39/17' became part of Flat C when the renovations occurred in 1995 and the door to the corridor was closed and another door positioned on the south wall of this bedroom. The smoke detectors at '39/18' and '39/19' were changed to thermal detectors in November 1995 by Mr Moore at the request of Vasan as the area had been converted to a kitchen/lounge. The smoke detector at '39/20' was changed to thermal detector on 3 January 1996 as a result of steam coming from bathroom. Previously, the smoke detector at '39/21' was replaced with a thermal on 24 June 1995 when the bedroom was renovated to a bathroom.

At this stage Villamanta's diagram of the known position and types of the detectors at the time of the fire may be useful.

Known position and types of detectors in Flat E after the fire.

KEY FOR PLAN

?/(**?**) Not known	**39** Circuit number	**24** Detector number on circuit
T/(**T**) Thermal detector	(**S**) Smoke detector	



Simply put, the question '*remains whether detectors 39/22 to 39/25 had also been changed to thermal detectors?'*.[157]

On 24 May 1995, Mr S. Neicho attended KRS following an alarm in Unit 30/31. The Service and Field Instruction notes record:

> *Requested to Alarm on Unit 30-31. Due to drill in unit 2 smoke detectors filled with dust. Changed to Heat. Restored Panel to Normal.*[158]

157 Villamanta Legal Service Submission, p. 42, para.6.7.5. See also Appendix 2.8 'Villamanta Legal Service Chronology of Events about Circuit 39'.

158 Exhibit 193 - L. Neicho 'LJN 21' No 0865.

Two (2) Type A detectors and 1 Hochiki base were installed. Mr S. Neicho considered that he carried out this work in Flat B. In February/March 1994, five smoke detectors had been installed in Flat B by Moore at the request of the builder O'Flynn. In May 1995, there was no renovation work being undertaken in Flat B. The only work being carried out where dust could have been created was in Flat E. In evidence Mr S. Neicho accepted the possibility that the work took place in Flat E. However, he still believed it to be in Flat B. Neicho remembered that the detectors were in a corridor.[159] The Service and Field Instruction includes the installation of an Hochiki base to a detector. As is put by the Villamanta Legal Service, the '*logical argument that he would not have needed a base in Flat E because all the detectors there had Hochiki bases would be equally true for those installed in Flat B'*.[160]

The Legal Service further submits that if '*Skye Neicho's belief is correct that the detectors he changed were in a corridor, it is not likely it was in Flat E as one of the detectors in the corridor of Flat E was a smoke detector until 3 January 1996 when Stephen Moore changed it to a smoke detector'*.[161] In addition, it is stated that it is '*the dust which links the change of detectors to Flat E. The Service and Field Instruction says they were "filled with dust"*.'[162] The Legal Service also submits that '*it was probable that the detectors Sky Neicho changed were in Flat E, though it recognises that the belief that the detectors changed were in corridors does conflict with this submission for at least one of them would have to be in a bedroom'*.[163]

On 26 June 1995 Mr S. Neicho again attended Units 30/31 to replace a detector. His Service and Field Instruction notes:

> *Due to work in Unit 30-31 smoke detector filled with dust. Replaced with type A head to fix problem.*[164]

An 'Hochiki type A' thermal detector was installed by Neicho. The renovation was of a bedroom to a bathroom.[165] The only renovation in Unit 30/31 changing a bedroom into bathroom was in Flat E. The MFB argues that the circumstances:

> *surrounding the change of two smoke detectors with thermal detectors in the corridor in Unit 30 as attested to by Mr Skye Neicho (see the chronology entry for 24 April 1995) strongly suggest that the change occurred at that time not in Flat B but in Flat E. The evidence established that four smoke (not thermal) detectors in Flat E were later replaced with thermal detectors (on 23 June 1995, 02 November 1995 and 3 January 1995: see the chronology entries). The two thermal detectors installed by way of replacement by Mr S Neicho were therefore likely to have been in bedrooms in Flat E or in one bedroom and at the end of the corridor near door 1. It is also noted that one of the detectors in Flat B alleged to have been changed to a thermal detector on this occasion was a smoke detector at the time of the fire (position 39/39 : see Exhibit 186).*[166]

The Villamanta Legal Service submitted that the '*last annual testing of detectors in Flat E was on 10 July 1995 (Statement of L. Neicho #LJN 18 No 8451). We do not have any records of the*

159 Transcript, p. 3880.

160 Villamanta Legal Service Submission, p. 42, para. 6.7.5.

161 Villamanta Legal Service Submission, p. 43, para. 6.7.5.

162 Villamanta Legal Service Submission, p. 43, para. 6.7.5.

163 Villamanta Legal Service Submission, p. 43, para. 6.7.5.

164 Exhibit 193 - L. Neicho 'LJN 21' No 0894.

165 Transcript, pp. 3847-3848.

166 MFB Submission, p. 61, para. 128(iii).

operation of detectors for this test ...' and notes that 'the work in Flat E does not conclude until October 1995'.[167] The Villamanta Legal Service drew attention to evidence '*which runs counter to its submissions'* on this issue:

> *On 3 November 1995 Mr Vasan requested Stephen Moore to assess if the detector system in Flat E conformed to code. Mr Moore could not visualise entering the bedroom area (4052). However this does not mean he did not do so. Mr Moore believes there were smoke detectors in the bedrooms of Flat E.*
>
> *Jonkar Industries gave evidence that the changes of detector when renovations are in progress are temporary. When the renovations cease the smoke detectors are restored where such restoration is appropriate to the use of the building. However no dockets were tendered in evidence to support this claim. Further Kew management was not in the habit of informing Jonkar of its intention to renovate, and, VLS submits, was unlikely to advise when the work had been completed.*[168]

However, Mr Moore stated that he checked the smoke detectors in the Flat E bedrooms when he attended there in November 1995 at Vasan's request. In evidence, he was not so certain. The MFB suggested:

> *But Mr Moore gave evidence that these detectors were in the bedrooms in Flat E when he performed work in the kitchen living area of that flat in November 1996 (T4051-4060, 4063-4, 4148-4150, 4156-6, 4159-4160). This evidence should not be accepted. Mr Moore did not perform work in Paul's bedroom and his recollection of his inspection of the detectors in that and the other bedrooms was too vague to be reliable (see especially T4056-7 and 4058-4060).*[169]

Certainly, it is accepted that Mr Moore installed smoke detectors in all of the bedrooms in the area in 1994 (pre-renovation). But, when pressed, he was unable to recall checking each of the bedrooms for smoke detectors in November 1995. For example, part of his evidence on this issue was to the effect:

> *I remember walking down in this direction. 1 sort of – I don't remember being down this end, I just remember walking from this area into the start of the corridor. That's a bit vague but that's what I can remember.*
>
> *Mr Dalton: That's the best of your recollection?*
>
> *Answer: M'mm.*
>
> *Coroner: When you are talking about the corridor, the start of the corridor of Flat E from the kitchen area?*
>
> *Answer: Yes.*
>
> *Question: Going towards the bedrooms but not quite getting there?*
>
> *Answer: Yes.*
>
> *Question: Let me understand this completely. By that are you indicating that you have no separate recollection of actually going into any of those bedrooms beyond that point?*
>
> *Answer: I wouldn't – no I can't recollect actually going into each bedroom.*
>
> *Coroner: So if that's the case how do you recall the smoke detectors being in the bedrooms?*

167 Villamanta Legal Service Submission, p. 43, para. 6.7.5.

168 Villamanta Legal Service Submission, pp. 43-44, para. 6.7.5.

169 MFB Submission, p. 62, para. 128(v).

Answer: I didn't – I recollect seeing – I don't need to go right into the bedroom to be able to see the detector. It's a case of opening the door and then if there is, in a case where it's close to a light or a fitting, then I may need to go into the bedroom and I may need to get to the detector to measure it.

Question: But in indicating on the (indistinct) you don't indicate that you have got as far as the bedrooms at all?

Answer: No, I can't remember.[170]

The State of Victoria argues that there must have been smoke detectors in Flat E in November 1995 as Mr Moore said that he looked around in Unit 31 for a convenient place to locate the smoke detectors that he had removed from the new kitchen/living room area and found a replacement point at 39/14. But the Wormald Reply gives an alternative way of looking at this explanation:

Mr Moore had installed the smoke detectors in Flat E in September 1993 and the Hochiki thermal head in Flat D at 39/14. In November 1995, he did not check the bedrooms of Flat E, he assumed that the smoke detectors that he had installed were still there, and he went to where he knew that there was a Hochiki base at 39/14. ... Mr Moore was seeking to place smoke detectors in bedrooms wherever he could, he still had a spare Hochiki smoke detector head which he could have placed on one of the Hochiki bases in the Flat B bedrooms. He assumed that those smoke detectors were also still in place. They were not.[171]

In addition, Mr Moore does not mention the detector in the corridor of Flat E at '39/24'. This detector site was destroyed during the fire, so it remains in question. Further, Mr Moore does not mention the smoke detector he changed to a thermal in June 1995 because the bedroom had been changed to a bathroom during the 1995 renovations. On this issue, Jonkar submits that some parties would have the court believe:

that Stephen Moore engaged in the extraordinary practice of taking the spare smoke detector he had, as a result of removing it from the newly created kitchen in Flat E, and walking all the way to bedroom 24 in Flat D to install the smoke detector – when there were apparently no smoke detectors in Flat E bedrooms immediately where he was working. This single piece of evidence, that Stephen Moore did indeed take that spare smoke detector to bedroom 24, is fatal to the theory that Jonkar removed the smoke detectors from the Flat E bedrooms. Not only does it prove that Stephen Moore is thorough in his work practices: why would he bother to improve the Flat D situation when he had only been requested to check on Flat E? Not only does it prove that Stephen Moore was well aware of the importance of having smoke detectors in bedrooms why would he bother to remove a functional thermal detector from bedroom 24? It proves that there were smoke detectors in the Flat E bedrooms on 2 November 1995.

This submission has been considered. It is not accepted that Mr Moore confirmed the positioning of the smoke detectors in the bedrooms of Flat E by inspecting them in November 1995.

Earlier, on 6 November 1994, Mr L. Neicho attended at KRS (Unit 30/31) following two false alarms and changed a smoke detector for a smoke detector. Mr Neicho stated that it had occurred in the corridor in Flat B. However, the room was noted in the MFB fire report as being in Kenny England's room. The evidence appears to place the room as the second bedroom on the left (consistent with Flat E and the room of fire origin).

Three staff gave evidence about where Kenny England may have slept. Mr Patrick O'Hare identified it as being bedroom 2 of Flat E:

170 Transcript, pp. 4058-4059.

171 Wormald Submission in Reply, p. 5, para. 2.12.

just after the amalgamation, before the renovations, he was in the bedroom, the door marked 2.[172]

The Deputy Unit Manager, Ms. Tosevski, puts the amalgamation of Units 30/31 as being October/November 1994. This, submits the State of Victoria, places the position in some doubt, because:

> *if amalgamation took place in October then Kenny England's bedroom was not Flat E however if amalgamation took place in November the bedroom, according to witnesses O'Hare and Tosevski, was in Flat E.*[173]

What is not considered in the Submission of the State of Victoria is the evidence of Mr Free:

> *Mr Redlich: Can you tell His Worship please can you remember any of the instances where you were aware that smoke detectors had been activated?*
>
> *Answer: There was one day I don't know whether it was the Saturday or a Sunday in November 1994 that I attended two alarms in Unit 31 and they were smoke detectors in the bedrooms. ...*
>
> *Question: Are you able to indicate what area the smoke detector was in that was activated?*
>
> *Answer: Around that area.*
>
> *Question: Yes, can you identify doorways so we know what room you are speaking of?*
>
> *Answer: Doorway 3.*
>
> *Coroner: That's Flat E is it?*
>
> *Answer: Yes, Your Worship.*[174]

It is noted that Mr L. Neicho says that it was in the corridor of Flat B but he remembered '*one call to the bedroom* ... [and] ... a*nother call to the corridor'*.[175] It was in his re-examination that he first mentioned the call to the bedroom. He also recalled asking '*somebody which was Kenny (?) Ingle's (?) room'*.[176]

The MFB submits that '*Mr Leslie Neicho's change of a detector in Kenny England's room was, on the evidence, in a Flat E bedroom. But it was apparently a replacement of a smoke detector with a smoke detector (T4459), although this cannot be found with any real assurance'*.[177] Jonkar argues that the suggestion that Mr L. Neicho worked in the bedroom of fire origin is *'not consistent with Mr Neicho's evidence and the Jonkar service field instruction form 1226 (LN21) and invoice 1500 (LN22). Not only does the field instruction form specifically refer to unit 30, but the documentation shows that a <u>smoke</u> detector was installed as a replacement*'.[178]

The work was done by Mr L. Neicho in the bedroom of fire origin.

In addition, Wormald submits that:

> *[i]f the MFB False Alarm Report is correct, the detector Mr Neicho worked on was 39/22 in the bedroom where the fire originated. If that smoke detector was replaced with a thermal because a difficult client, as Kenny England is said to have been, had set the*

172 Transcript, p. 2299.

173 State of Victoria Submission, p. 171, para. 1.17.

174 Transcript, p. 2460.

175 Transcript, p. 4456 et seq.

176 Transcript, p. 2288.

177 MFB Submission, p. 62, para. 128(vi).

178 Jonkar Reply, pp. 3-4, para. 1.2(f) (emphasis added).

alarm off twice in one day, it would be consistent with the practices adopted at KRS – in relation to renovations, steam and the like – to have replaced that smoke detector with a thermal detector. Although there is a degree of speculation in this, it is the closest the evidence gets to explaining how there came to be a thermal detector rather than a smoke detector at 39/22.[179]

It would be difficult to accept that the MFB did not accurately record the name 'Kenny England.' Also Mr L. Neicho was looking for England's room.

For another, more technical reason, the MFB Submission is supportive of this approach:

It can be concluded with a high degree of assurance that the detector which gave the alarm was neither an operational smoke detector in the compartment of fire origin, nor an operational smoke detector in Flat E. It is submitted that the likelihood is that the detector, which activated the circuit 39 alarm, was a thermal detector in that compartment operating at the extremity of its sensitivity parameters. Mr England accepts that this is a possibility (Exhibit 201 at 16 and 30).[180]

In reaching this conclusion, the MFB examined the evidence of Inspector Martin and makes the following points:

(1) [T]he activation of a smoke detector anywhere in Flat E is very unlikely. If there was a smoke detector anywhere in Flat E it would have been activated well before the delay of 7 minutes 45 seconds which occurred.

(2) As to Jonkar's assertion 'that there were smoke detectors in positions 39/22, 39/23, 39/24 and 39/25 (being the bedrooms of doors 2, 3 and 4 and in the western end of the corridor) in Flat E. If there were smoke detectors in these positions, none of them were functioning, which also seems very unlikely. (The possibility of a total wiring failure is not consistent with the fact that, if no detector in Flat E gave the alarm, it must have been a detector in position 39/16 or 39/17 in Flat C, both of which were on the Flat E wiring loop.)

This indicates the presence of thermal detectors, not smoke detectors, in Flat E.[181]

The MFB states that the '*facts thus point to only two likely scenarios the failure or delay of all three or four of the smoke detectors alleged to be in situ in Flat E, or the conclusion that all of the eight detectors in Flat E were thermal detectors. Of these the second is the highly probable'*.[182] There is one other possibility not considered: that damage to one or more detectors in Flat E restricted its operation, and that, combined with closed doors in some of the other bedrooms until late in the fire development, limited the operation of the alarms.

The MFB points to Flat B to support the argument that there were no smoke detectors in Flat E. It is noted that neither in the State of Victoria's Submissions nor in the Reply is the issue of Flat B substantially argued. The MFB states (of Flat B) that there were no smoke detectors:[183]

All of the smoke detectors that had been installed in the bedrooms in that flat had been replaced by the time of the fire, irrefutably contrary to the evidence of Jonkar Industries (see the events described in the chronology in Appendix 1 ("the chronology")). That

179 Wormald Submission, p. 23, para. 2.17.

180 MFB Submission, p. 59, para. 127.

181 MFB Submission, p. 60, para. 128(i). (Note: The quote has been prècised by the author.)

182 MFB Submission, p. 60, para. 128(i).

183 See Exhibit 186 - McCumisky Plan.

company was responsible for the maintenance of the alarm system in Flat B and the evidence supports the probability that, over time, it replaced the smoke detectors in Flat B with thermal detectors. This having happened in Flat B, the probability that it also happened in Flat E is all the stronger.[184]

The position is summarised by the MFB as follows:

- *the bedroom of fire origin (bedroom door 3) – no properly functioning smoke detector, probably a thermal detector operating at the extremes of its parameters;*
- *bedroom door 2 – no properly functioning smoke detector, probably a thermal detector;*
- *bedroom doorway 4 – no properly functioning smoke detector, probably a thermal detector;*
- *the hallway nearest door 3 – a thermal detector;*
- *the hallway near door 2 – no properly functioning smoke detector, probably a thermal detector;*
- *there was a thermal detector in the bathroom, a thermal detector in the living area and a thermal detector in the kitchen/meals area;*
- *bedroom door 9 – a smoke detector;*
- *the hallway near door 10 – a smoke detector or a thermal detector.*[185]

One of the additional reasons put by Jonkar as rendering the theory that there were no smoke detectors in Flat E unacceptable was that '*Vasan would have to have been mistaken when he stated that there were smoke detectors in the Flat E bedrooms'*.[186] Vasan did not go into the bedrooms of Flat E when he checked on the detectors in the kitchen/lounge in October/November 1995. He assumed there would be smoke detectors in the bedrooms:

Mr Vasan: I was very keen to look at only the kitchen/living area so that was my main observation.

Mr Bell: So the answer is, no, you did not make any observations of that area?

Answer: No, I haven't, no.[187]

Thus Mr Vasan's evidence is of no assistance.

The delay of time for the detector alarming on the night, the persistent removal of smoke detectors and replacement with thermals by Jonkar (compromising safety) combined with evidence of a low number of smoke detectors remaining after the fire leads to the conclusion that it is likely that there were no smoke detectors in the bedrooms of Flat E. It is likely that they had been replaced with thermals. There are other possibilities, but on observing Mr L. Neicho in the witness box, the other possibilities are certainly less likely.

4.1.12 LACK OF PLANS ON SITE: DIFFICULTY FOR SAFETY AND INVESTIGATION

The failure to have reliable, updated plans of the then existing fire alarm system (in accordance with the Australian Standards) available on site has caused obvious difficulties for the investigation.

184 MFB Submission, pp. 60-61, para. 128(ii).

185 MFB Submission, p. 63, para. 130.

186 Jonkar Reply, p. 3, para. 1.2(e).

187 Transcript, p. 6139.

The direct result of the lack of reliable and accurate plans has extended the time of the inquest and created difficulties of proof.

The lack of plans means that any changes to the fire detection system have not been monitored. Accordingly, safety may well be compromised. It is also indicative of a failure in management to regularly audit the fire detection system. Had KRS management taken only a slight interest in the state of its existing fire safety hardware systems, it would have insisted on obtaining plans. It had a number of years within which to do so.

4.1.13 WORMALD'S ALLEGED INVOLVEMENT IN THE INVESTIGATION

Counsel for the State of Victoria put that '*as late as the fifth month of hearing evidence, statements from Wormald witnesses had neither been obtained nor a proper examination of the conduct of Wormald personnel been undertaken. The Coroner was still under the mistaken belief that simply because circuit 39 operated on the night of the fire, the detection system was fully operational'*.[188] Counsel for the State of Victoria is critical of the MFB for its approach to Wormald's involvement. In this regard it submitted that problems with the investigation were manifest '*from virtually day one of the investigation (in circumstances where Wormald were recruited as a member of the investigation team) which continued both throughout the proceedings'*[189] and was continued in the written submissions of the MFB to the Coroner.

What appears not to be developed in this submission is that, by the very nature of coronial investigation, the ultimate responsibility for the investigation, its conduct and direction rests with the Coroner. The submission of the State of Victoria is factually incorrect. Simply put, Wormald were not '*recruited as a member of the investigation team'* nor did it become a member of the investigation team.[190]

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188 State of Victoria Submissions in Reply, p. 485, para. 1.70.

189 State of Victoria Submission in Reply, p. 486, para. 1.74.

190 As a result of the State of Victoria Submissions, further inquiries were made of Detective Sergeant John Deans (Victoria Police State Crime Arson Squad). In a memorandum to the Officer in Charge, State Crime Arson Squad (with copy to the Coroner), dated 4 August 1997, Deans states (of the allegation that Wormald were involved in the investigation):

1. ....This allegation is completely incorrect, Wormald played no part in this investigation of the fire at Kew Cottages on the 8th., of April 1996.

2. As part of the Police Investigation, I was informed that Wormald was the company that was conducting the fire up grade at Kew. I was further informed that this work in Unit 30/31, had stopped on the 17th., of January 1996. I was also informed that the Project Manager was Bruce HOSKIN. I contacted Wormald on 2.7.96, spoke to Bruce Hoskin and requested a statement. On 15.7.96 Hoskin attended at the Arson Squad Office at St.Kilda Road and made a statement, which was attached to the Coroners Brief. I obtained the statement from Hoskin and covered that Wormald was the company conducting the fire up grade, how advanced the work was in Unit 30/31 and the reason why the work had stopped some months prior to the fire. The reason given for stopping work was the Asbestos issue.

3. After I submitted the Brief to the Coroners Office, I had a meeting with Mr HICKS, who had been appointed to assist the Coroner in the Kew matter. A request was made that possibly some documents as to detail in Mr Hoskin's statement might be appropriate. I again contacted Wormald and Solicitor Tom Yuncken (Arthur, Robinson and Hedgewick). On the 20th of September 1997, I viewed the Wormald File regarding works at Kew Cottages. I obtained copies of site meeting memo's and contract documents which were produced at the Inquest.

4. I have documented eight (8) occasions, where I met with M.F.B and F.S.L. personnel re the Kew Cottages inquiry. This is not in the form of minutes and nobody from Wormald or representing Wormald were present. The meetings consisted of up dates on the progress of the individual parts of the investigation.

The MFB's Reply on the same issue referred to in the State of Victoria's Submissions comments on this point:

> *As to paragraph 1.57 on page 191, the submission that Wormald was enlisted to play a prominent role in the fire investigation is incorrect. From the point of view of the MFB Wormald were not afforded a special status in the fire investigation. There was no failure on the part of the MFB, and in particular on the part of Inspector Martin, properly to consider all reasonable explanations for the delay in the giving of the alarm and certainly no failure to examine any apparent conduct of Wormald. No evidence came to light during the fire investigation which required any further examination of Wormald than was in fact undertaken, although evidence did come to light in the course of the inquest which required and received further investigation.*[191]

It is noted that Wormald also denies the State's claim, and explains how it relocated a sub-panel out of Building 37 after the fire as an emergency measure, responded to inquiries of Sergeant Deans, and provided a statement and access to documents. Additional statements were provided when requested by the Coroner's Assistants or the Coroner.[192]

The State of Victoria is critical of the investigation in that '*the Coroner was not assisted as he ought to have been due to the lack of investigation of a company whose conduct may well have been the direct cause for the system's failure on the night of the fire'*.[193] Further, it is stated that '*at no stage throughout the investigative process was any investigation directed) at the possibility of Wormald having interfered with the existing wiring and/or detection system in Flat E'*.[194] This is factually incorrect. The issue was considered and dealt with, by way of example, with the provision of statements and an inspection on site by the court. Witnesses were also examined in the witness box. The decision as to whether to require further investigation on this issue rests with the Coroner. There was no indication that there was any evidence to justify taking the inquest down that path, and further, the parties were given every opportunity to argue this issue.[195]

It is noted that the consultant engaged by the State of Victoria[196] in its report did not raise the issues of the various theories such as 'bypass' or 'reverse polarity'.[197] While it might be said that the consultant's report was completed before these issues were raised, the combined statement of the experts, which was finalised towards the end of the inquest, does not raise many of the State's suggestions as applying to Wormald. There was every opportunity for these issues to be raised by the expert before the close of evidence. In addition, the issue of the alleged involvement of Wormald 'on the investigation team' was not raised with either Inspector Martin or Detective Sergeant Deans during their evidence.

The submission of counsel of the State of Victoria fails to consider the very nature of the inquisitorial process. The '*inquest'* is part and parcel of an ongoing '*investigation'*. An inquest is dynamic, and in complex cases such as the fire at KRS, further material will invariably come to light during the

191 MFB Submission in Reply, p. 4, para. 9. See also the MFB's comment in its Reply, p. 4, para.10.

192 Wormald Submission in Reply, pp. 19-20, paras. 6.1-6.6.

193 State of Victoria Submissions in Reply, p. 482, para. 1.61.

194 State of Victoria Submissions in Reply, p. 482, para. 1.62.

195 See also the MFB Submission in Reply, p. 4, para. 10.

196 Exhibit 201 - Warrington Fire Research.

197 But see Exhibit 201, p. 16, where Warrington mentions that, as an alternative, '*complete failure of the below ceiling detection system in Flat E*' could have been an explanation. In this case reliance would be placed on an adjoining areas' system for the alarm. Warrington also comments that '*[a] detailed investigation of the remaining wiring after the fire was unable to confirm the status of the detection system within Flat E at the time of the fire due to the extent of the fire damage. Details of the investigation are included in Appendix 1'*.

hearing. This can occur at any time during the hearing or even after submissions.[198] The information on the potential role of Wormald was but an example of a developing complex investigation where information is provided and examined at any stage.

New information is a regular occurrence in the coronial jurisdiction, which can result in differing approaches, changing views and understanding by both experts, the parties and the Coroner. Examples of new information in this inquest can be seen in the late evidence of Mr Paino and in statements provided by the State of Victoria in its submissions and replies.[199] The most significant evidence disclosed after the close of evidence were the statements of Messrs Winn and Newton following the separate representation of BSA.

This is not to say that improvements in investigatory processes cannot be achieved following lessons learnt in this inquest. During the running of the KRS inquest (and after the initial Victoria Police Arson Squad/MFB investigation on behalf of the Coroner), it was decided to rely on the parties to assist in providing statements and material from their personnel and files. Thus the court was assisted by statements and information directly provided by parties such as Jonkar, SSL, Wormald and Paino. It is noted that the State of Victoria, through its counsel and instructing solicitors, was heavily relied upon by the court to assist in providing reports, documents, plans and statements from its staff, consultants, experts and some subcontractors.[200]

4.1.14 CONCLUSION ON THE STATE OF THE SYSTEM

It is unlikely that the myriad of theories ranging from bypass and wiring problems to reverse polarity had any bearing on the failure of the system to operate as an early warning of fire on the night. It is likely that there were no smoke detectors in all the bedrooms of Flat E by the time of the fire. That was the most likely cause of the failure of the system to give early warning of fire in Flat E. The changing of smoke detectors with thermals on a 'temporary' basis was a regular part of the maintenance work at KRS. There is no confidence that they were all re-instated.

Nevertheless, the possibility of detector damage in the bedroom of fire origin cannot be totally excluded. It remains somewhat puzzling why after the 1995 renovations to Unit 31 there was not some painting undertaken. In view of the 1994 Fabric Survey's comments on painting in Building 37, this cannot be totally excluded in spite of Mr Vasan's late statement. It is unlikely that all smoke detectors in the remaining bedrooms and the corridor had also been similarly compromised. However, as it cannot be determined at what time during the fire sequence the bedroom doors were opened, the puzzle remains.

Thus, with evidence of the possibility that a damaged smoke detector can compromise the alarm system without any warning of the problem, the issue cannot be finally determined. Painting of detectors cannot be totally excluded.

198 See, for example, the new evidence in the police shooting case of Frederick John Lewis (Coroner's case file no. 3334/95), where at pp. 64-65 it is stated:

At a late stage in the inquest, after submissions and before the finding was complete, it was discovered that significant evidentiary material had not been forensically examined. That material was the police officer's clothing. On examination, that clothing (in the possession of the Forensic Science Centre) was found to have significant bloodstaining from both the officer and the deceased. An item was found in the pocket of the officer's trousers with blood products from the deceased ...

It is of concern that items are recovered from a scene and not inspected at the earliest time for possible forensic evidence. The new evidence of the bloodstaining on the clothing is an important aspect of the investigation in this case. [Recommendations were made on this issue].

199 See, for example, Mr Vasan's statement on painting of Unit 31 or Mr Taylor's on discussions with Mr Lee (BSA).

200 See, for example, Mr Lai, Professor Adler, Warrington Fire Research, Messrs Winn and Newton.

Although the remaining theories have been rejected as unlikely, the conclusion by the Warrington Report as to the probability of failure of smoke detectors raises concern about system reliability:

> *Since a number of non-compliances with the design code were identified in Units 30 and 31, it is considered that the system would have a below average reliability and therefore there was a significant probability for failure of the detection system in place at the time of the fire.*[201]

This leaves some areas of doubt.

4.2 POTENTIAL FOR SURVIVAL UNDER THE EXISTING FIRE ALARM SYSTEM

4.2.1 FIRE DEVELOPMENT SEQUENCE

As there was no compellable witness to the initial fire development, it is necessary to examine a number of facts to determine the fire development sequence. The starting point is the initial automatic alarm call direct to the MFB. That occurred at 22.56.12 hours when a detector on circuit 39 activated the alarm. A second circuit (40) operated shortly thereafter. Circuit 40 runs the thermal detectors contained in the roof space of Building 37. There is no dispute that the roof space detectors are all aged thermals.

Mr Chea was the first person to the fire, and by this stage it was well alight. He was in the kitchen at the front of the building when telephoned by Barry Wales from Administration. This call was made about two minutes after the alarm. The instructions were to evacuate. After alerting Mr Frlan, Chea recalled in his statement:

> *At this stage everything in the building was quiet and I couldn't see or smell any smoke.*
>
> *I ran through the building to check Flats C and D banging the wall and doors as I went and then went to check Flat E. As I turned into the kitchen adjoining flat E, I saw smoke suddenly billowing from the ceiling above the corridor which the bedrooms to this flat lead off. This was illuminated by the toilet light behind me. It is normal practice to leave the toilet lights on over night so that the clients can get up and go to the toilet. The light behind me was the C Flat toilet light. I can't remember if the E Flat toilet light was on or not. All I could see was the smoke coming out of the ceiling. I couldn't see any flames or feel any heat at this stage. I attempted to turn the hallway light to the Flat E bedrooms on but it wouldn't work. The smoke filled the room very quickly so I started to crawl under the smoke towards the bedrooms but was driven back by the smoke because I couldn't breathe. While doing this I was screaming continually trying to alert the guys. I went back into the small corridor which leads into the E Flat kitchen to get my breath and then back into the smoke. <u>This time I could see flames coming from the ceiling in the place that I originally saw the smoke come from.</u> I couldn't see anything else because of the smoke and I didn't see anybody come out of the E Flat bedrooms. I can't remember if any of the bedroom doors were shut ... This time I was forced back by smoke and heat so I gathered my breath in the corridor once again and tried to crawl back into Flat E under the layer of smoke, but I didn't get far before being forced back into the corridor. The fire and smoke had spread so quickly that I couldn't get back into Flat E.*[202]

201 Exhibit 201, p. 17.

202 Coroner's Brief - Police Arson Squad, Chea Earpeng's statement (emphasis added).

After being alerted by Chea, Mr Frlan telephoned Wales in Administration to confirm that it was not a drill. Wales then telephoned staff in other units for help. The first staff on the scene also confirmed a well-developed fire. They stated that the fire had penetrated the roof. Firefighters who arrived at KRS between 23.01.49 hours and 23.04.59 hours also observed a well-developed fire.[203] An example of staff observations can be seen from the statement of Ms. Catherine Backhouse who was on duty in Unit 21 on the night of the fire. Backhouse was one of the first members of staff to reach the scene of the fire. She was in Unit 21 when telephoned by Wales. By the time she left the unit, she observed the flames *'coming out of the roof in the middle of the building'*.[204]

The MFB submits that although '*the fire scene was largely destroyed ... there is evidence enabling the experts to describe the nature and progress of the fire. This includes the structure and nature of furnishings in Bedroom 1, Flat E. The observations of state of fire development made by the earliest witnesses to the scene also assist'*.[205] The MFB used the 'fire test' to examine the various theories.

Mr England of Warrington Fire Research says of the 'fire test':

> *The above results are consistent with those expected for a fire of its type with a period of slow or incipient fire growth followed by a short period of rapidly accelerating growth leading to full room involvement.*[206]

The fire test showed that, although slow to grow, '*the fire nevertheless generated a great amount of smoke and produced life threatening conditions during its developing stage'*. [207]

Warrington estimated the time of ignition '*as being 7 minutes 45 seconds approximately prior to alarm (known to be at 22.56.12 hours), that is at about 22.48.27 hours'*.[208] The MFB explained that the 'fire test' indicated that:

> *untenable conditions were reached in the compartment of fire origin at about 180 seconds after ignition. The computer modelling conducted by the MFB produced a time for untenable conditions in the compartment of fire origin of about 340 seconds after ignition. The deceased would have died shortly after untenable conditions were reached, not necessarily exactly when those conditions were reached. It is to be noted that no one died in the bedroom where Paul set alight the fire and that all of the deceased except Mr Negri managed to move some little way at least from their own bed; Mr Aldridge managed to move into the hallway and Mr Newman and Mr Grant managed to move into the living area. The doors to the three bedrooms, including Paul's bedroom, were open.*[209]

Finally, the MFB concludes that:

> *it is probable that the deceased were overcome by smoke as Flat E became smoke logged during the development of the fire in Paul's bedroom and the spread of the fire beyond that bedroom, and that the deceased died within about 390 seconds (6 minutes 30 seconds) of ignition or at about 22.56.00 hours. It is possible that the deceased who did not die intheir own bedrooms (namely Mr Aldridge, Mr Newman and Mr Grant) managed to live a*

203 See discussion in the Findings in **PART 3 Management of Risk and System Deficiencies 3.8 Fire Drills and Evacuation Procedures.**

204 Coroner's Brief – Police Arson Squad, p. 127.

205 MFB Submission, p. 49, para. 108.

206 MFB Submission, p. 49, para. 108; Exhibit 201, p. 14.

207 MFB Submission, p. 49, para. 109. See also Exhibit 4, pp. 42-106; the evidence referred to below; evidence of Mr Lai in Transcript, pp. 3469, 3477-3480.

208 MFB Submission, p. 49, para. 110.

209 MFB Submission, p. 50, para. 111. See also Exhibits 3; 4, pp. 104, 112; 201, p. 8.

little longer as their place of death suggests a longer period of struggle to survive. But the strong probability is that all of the deceased had died prior to the earliest entry of a rescuer (Mr Chea) into Flat E.[210]

The Warrington Report states that:

[i]t is therefore reasonable to conclude that the most likely scenario would be similar to the simulation test performed at Port Melbourne by the MFB and that activation of the alarms must have occurred 7 or more minutes after ignition compared to approximately 45s which would be expected if a functional smoke detection system had been present in Flat E.[211]

Inspector Martin stated that:

[g]iven that the operation of a correctly positioned and operating smoke detector is expected at approximately 40 seconds following ignition, smoke detector operation has not occurred within the compartment of fire origin.[212]

4.2.2 EVACUATION ON THE NIGHT

The MFB Submission suggests '*that evacuation within the first five minutes would have saved the lives*' of the residents. In its Submission, the MFB examined in detail the actual responses of staff on the night of the fire in order to determine whether rescue would have been viable with a properly operating alarm system. After considering the evidence of a number of staff and fire officers, the Submission concludes:

Thus Mr Chea, Mr Frlan, Mr Free, Mr Sen and Mr Ansorge arrived within about the first 5 minutes of the fire prior to the MFB's arrival. The first MFB appliance and crew arrived at about 5 minutes 37 seconds after the alarm of fire, and two additional appliances and crews arrived at 23.02.18 hours and 23.04.59 hours and others subsequently (Exhibit 8). Within about 1–3 minutes after the first arrival of the MFB eight or so other staff from other units arrived to render assistance.[213]

The MFB concludes that Mr Chea's attendance at Flat E would have occurred within a short time of the alarm of fire, probably within about one minute or a little later. The next to arrive (excluding Frlan) would be Free and Sen. The MFB considers Free's response in these terms:

After speaking briefly to the MFB Mr Free went to Unit 30/31. He arrived before Mr Henderson, as did some other staff. Into this skeleton of known facts may be placed certain other evidence about the attendance of staff in the earlier stages of the evacuation.

The MFB estimated that Mr Free arrived within about 4 minutes of the alarm of fire. He gave evidence that the sequence of events was that, after the alarm was given, he took about 30 seconds to ring the MFB (T2499 and T2450). He stated that he took about 3 minutes 5 seconds to get to door 23 (T2449) and saw Ms Backhouse coming up from Unit 21 on the way (T2450). He gave evidence of entering through door 23 (after a short delay caused by a difficulty in opening it) and then assisting with the evacuation. From the evidence of the MFB call history (Exhibit 8), as clarified in the inquest (see T2579), it emerged that Mr Free's telephone call to the MFB occurred at about 22.57.10 hours. This is about 1 minute after the alarm of fire, a delay which Mr Free could not explain

210 MFB Submission, pp. 50-51, para. 112.

211 Exhibit 201, p. 17.

212 Exhibit 222, para. 6.

213 MFB Submission, p. 55, para. 120.

(T2581). He did not accept that it may have been 4 to 5 minutes before he was present at Unit 30/31 (T2554) and stated that he was inside Unit 31 evacuating clients by that time (T2582).[214]

The Submission also examines Inspector Martin's estimates of the time it takes to travel between Administration and Unit 30/31, and suggests that:

it takes about 1 minute 55 seconds to travel the distance between the administration building and Unit 30/31 (Exhibit 104). Assessing the evidence of Mr Free as a whole and in the context of the evidence generally, it seems likely that he took a little longer to arrive ... [than] *... suggested in evidence, but still well in time to assist in the evacuation if an earlier alarm had been given.*[215]

It suggests that the evidence establishes:

that starting from the time of the alarm of fire at 22.56.16 hours the first persons to respond outside Unit 30/31 were Mr Wales and Mr Free. Relevantly Mr Wales telephoned Unit 30/31 to give the alarm of fire as soon as possible, probably within 30 seconds or so. Mr Chea and Mr Frlan were not aware that there was a fire in their own building and that nine men in their care had died in that fire. Mr Frlan verified the call with Mr Wales. Mr Chea and Mr Frlan responded by starting the evacuation process, again as soon as possible and probably within 30 to 60 seconds. Having telephoned the MFB Mr Free was by this time or shortly afterwards on his way to Unit 30/31 and he entered door 23 of the unit with Mr Sen upon arrival, probably within about 4 minutes after the alarm of fire. Mr Ansorge arrived shortly afterwards, but before the MFB.[216]

There is no reason to believe that the staff would have reacted any differently had the alarm been correctly given. The MFB concludes that:

[i]t was earlier submitted that the deceased died within about 390 seconds (6 minutes 30 seconds) of ignition. The evidence that there was a delay of some 7 minutes 45 seconds in the giving of the alarm of fire has already been referred to.[217]

The MFB also concludes that the evidence:

as to the response of the staff of KRS (both within Unit 30/31 and elsewhere) and the MFB, as analysed above, shows that had the alarm of fire been given 7 minutes 45 seconds earlier then Mr Chea and Mr Frlan, assisted at least by Mr Free, Mr Sen and Mr Ansorge, and then by the MFB fire fighters, would have contained or extinguished the fire and evacuated the occupants of Flat E prior to the onset of critical conditions in that flat. The evidence as to what would have occurred, had the early alarm of fire been given, demonstrates yet again that it is the first 5 minutes of a fire that are critical to life safety.[218]

But it is still critical of the actual response of staff as:

[w]hile the above conclusion is established by the evidence on the balance of probabilities it must be noted that the KRS staff in particular would have been confronted with a terribly threatening situation. There were only two staff on duty in Unit 30/31 on the night of the fire to care for 45 intellectually disabled clients. This is too few and would

214 MFB Submission, p. 52, para. 116.

215 MFB Submission, p. 53, para. 116.

216 MFB Submission, p. 55, para. 120.

217 MFB Submission, p. 56, para. 122.

218 MFB Submission, p. 56, para. 122.

likely have impacted adversely on the evacuation process. Only three staff from other units and the administration area arrived in time to assist Mr Chea and Mr Frlan within the first 5 minutes, a poor result for the KRS evacuation system as Mr Wales (T1830) and Mr Free (T2544) acknowledged.[219]

In conclusion the MFB says that:

[h]owever taking into account the evidence of the staff response as set out above, and recalling that a number of trained fire fighters with equipment were on scene within 5 minutes 37 seconds of the alarm of fire, the probability is that the fire could have been contained and extinguished and the clients of Flat E evacuated without loss of life.[220]

The argument is persuasive that a properly operating smoke detector alarm system would have probably resulted in the nine residents being evacuated.

4.2.3 POTENTIAL TO SURVIVE WITH A FUNCTIONING SMOKE DETECTOR

An important question to determine is whether a properly functioning smoke alarm in the bedroom of fire origin of Flat E would have resulted in the residents surviving. The MFB Submission suggests that this is likely. As already discussed, the MFB Submission considers that critical examination of the response times on the night following an early alarm would have enabled KRS staff and MFB firefighters to save the men. The MFB Submission opines that the evidence of *'Mr Chea, Mr Frlan and the KRS and MFB witnesses ... as to the advanced state of the fire on initial observation is consistent only with the conclusion that the nine men died some time prior to the arrival of the first staff on scene'*.[221]

The MFB states that *'functioning smoke detectors would have saved the lives of the deceased.'* In view of its earlier submissions on the likelihood of rescue, it *'follows that the lives of the deceased would have been saved had a functioning smoke detector in the compartment of fire origin given an alarm of fire'*.[222] However, the Submission also suggests that this *'cannot be guaranteed due to the great difficulty of the task of evacuating so many disabled clients from a complex structure in an emergency situation, as stated above. The lives of the deceased would certainly have been saved had a sprinkler system been installed in Flat E'*.[223]

The MFB Submission documents that the 'fire test' shows that a functioning smoke detector would have activated from ignition either at 38 seconds;[224] 45 seconds;[225] or 60 seconds.[226] Any of these times were well prior to untenable conditions being reached *'even in Paul's bedroom and well in time to enable staff and the MFB to evacuate all of the occupants of Flat E'*.[227] Further, the MFB submitted that as:

functioning smoke detectors elsewhere in Flat E would have activated within about 150 seconds of ignition (Exhibit 222), these too would have saved the lives of the deceased. A sprinkler system would have extinguished the fire in the compartment of origin between

219 MFB Submission, p. 56, para. 123.

220 MFB Submssion, pp. 57-58, para. 123.

221 MFB Submission, p. 50, para. 111.

222 MFB Submission, p. 58, para. 124.

223 MFB Submission, p. 58, para. 124.

224 MFB Report, p. 103.

225 Exhibit 201 - Warrington Report, p. 17.

226 Mr Lai in Transcript, p. 3294.

227 MFB Submission, p. 58, para. 125.

about 190 seconds (the computer modelling – Exhibit 4 at 113) and 330 seconds (the test burn – Exhibit 4 at 104) well prior to the onset of untenable conditions in the final resting place of the deceased and in time for the evacuation of them all.[228]

To reinforce the value of sprinklers, the MFB stated:

As explained by Mr Lai, a combination of smoke detectors and sprinklers was needed to guarantee the survival of the deceased (T3298).[229]

In conclusion, a delay in alarm of almost eight minutes on the night of the fire clearly points to the absence of a properly functioning smoke detector in the compartment of fire origin. Had a smoke detector operated properly, it would probably have significantly altered the outcome.

228 MFB Submission, pp. 58-59, para. 125.

229 MFB Submission, p. 59, para. 125.

PART 5 BUILDING LAW AND THE FIRE

This Part deals with the issue of building law and public buildings. Recently, the State of Victoria has been working towards improving fire safety in public buildings. It has begun a process of requiring such buildings to conform to the same building law as applies to the private sector. This work commenced well before the fire at KRS.

Some of the difficulties of classification of buildings such as Unit 31 are considered, and the consequences for fire safety are examined.

The lead-up to the 1995 renovation of Unit 31 (which divided the building into flats) is discussed. The fire engineers at ULA working on the Project Comtrol Group (PCG) are found to have no knowledge of the renovations until such are complete. This is in spite of a recommendation in the ULA Report that fire engineers be involved in any renovations. Management at KRS approached a building surveyor – Ashlar – which had no previous involvement at KRS. Because of a communication breakdown, the building surveyor was not aware of the true background of the residents at KRS. The surveyor was not told of the imminent fire upgrade. The Unit was not inspected either before or after the renovations so the significance of the type of resident or the fire safety issue was not discovered.

Ultimately, it is found that management at KRS decided to proceed with the renovations knowing the risk and relying on the imminent upgrade.

5.1 FIRE SAFETY: BUILDING CLASSIFICATION, USE AND REGULATION

5.1.1 BACKGROUND

The existing Building Regulations and the Building Code of Australia became an issue during the investigation. Issues associated with building classification and use in the context of the intellectually disabled and mentally ill are not new. They had also been raised during the 1968 inquest into the Willsmere fire. A study of the relevant provisions of the Regulations and the Code indicates a degree of uncertainty about which, if any, provisions applied to the type of government buildings housing the intellectually disabled. This uncertainty persisted during building alterations, the lead-up to and fire upgrade at Kew. However, both before and after the fire, significant work was being done at legislative level to improve the situation.

The Submission of the State of Victoria puts that the extensive audit program which commenced in 1993 was a '*watershed for government and its departments reflecting a change in cultural approach and demonstrating a recognition that there needed to be a sensible review of the extent to which government buildings were not able to provide a reasonable level of fire safety in accordance with current fire safety standards'*.[1]

5.1.2 LEGAL AND HISTORICAL OVERVIEW

Building approvals in Victoria are administered under the *Building Act* 1993, the Uniform Building Regulations, the Victoria Building Regulations and the Building Code of Australia.

1 State of Victoria Submission in Reply, p. 251, para. 7.2.

Historically, building controls applying in the private sector did not apply to the Crown. However, in 1993, by the enactment of section 220 of the *Building Act* 1993, the Minister of Finance was empowered to prepare and publish guidelines to promote better building standards for buildings owned by the Crown and public authorities. This move was considered to be a major development in this area of building control. It is clear that a real and lasting attempt was being made to redress a significant historical problem with compliance. The ULA Submission positively comments that:

> *the Government has attempted to reduce the Government building fire safety deficit built up over many years of non-complying building activities.*[2]

The *Building Act* 1993 required Ministers of the Crown presenting annual reports with respect to the operations of departments or public authorities to table in Parliament a statement as to the department's or authority's progress in implementing the guidelines during the relevant period.

The ULA Submission comments that '*[b]oth of these measures were steps taken to advance Government building standards. However, whilst certification was required, the significant exemptions from the building permit system and from verification through inspections continued'*.[3]

Guidelines were published by the Minister for Finance in November 1994. The Guidelines were entitled 'Standards for Publicly-Owned Buildings', and were developed by the Office of Building of the Department of Planning and Development. The preamble to the Guidelines states:

> *They are designed to bring publicly owned buildings into conformity with statutory requirements applicable to the private sector.*[4]

Two particular 1994 Ministerial Guidelines relevant in this inquest are first:

> *New and Existing Buildings Conforming to Standards.*
>
> *New publicly owned buildings are required to conform with the Building Act 1993 and its Regulations as well as meet other statutory obligations which relate to health and safety matters. Existing publicly owned buildings are expected to be brought to a standard such that they are safe and fit to occupy.*
>
> *The Building Act requires the Crown to ensure that its buildings are designed in conformity with building regulations, that the plans for building works are certified, and then lodged with Local Councils.*
>
> *Mandatory inspection of building work (works) by a Building Surveyor and issue of Occupancy Permits (defined in the Act) are requirements on the private sector but not on public sector bodies. Nevertheless, public sector bodies are to ensure that public building works are completed in accordance with the certified plans and are fit for occupation, as required of private owners.*
>
> *Building Surveyors engaged to approve works on existing buildings will need to be satisfied that upon completion of the works the building will be safe and fit to occupy. This standard would be demonstrated by the surveyor's indication of a preparedness to issue an Occupancy Permit on completion of any building work.*[5]

The second relevant Ministerial Guideline is:

> *Buildings to be maintained in a safe and serviceable condition.*

2 ULA Submission, p. 15, para. 2.2.

3 ULA Submission, p. 12, para. 2.19.

4 Exhibit 298.

5 Exhibit 298 – Guideline 1 (emphasis added).

Publicly owned buildings are required to be maintained in a safe and serviceable condition. Departments should have mechanisms in place to provide for regular building inspection, condition reporting and specification of required rectification and maintenance works. The mechanisms should also provide for reports to cover the anticipated cost of those works and estimation of the likely remaining useful life of the building upon completion of the works.

The mechanisms adopted should ensure that in the case of new buildings the inspection and reporting processes are conducted in accordance with the requirements of the Regulations (see Building Regulations 1994, Part 11 (eleven), which require inspection of essential services at least annually). The mechanisms adopted for existing buildings should ensure that the inspection and reporting processes are such that the building is safe and fit to occupy. Such inspection and report mechanisms will form the basis for periodic revaluation of assets.[6]

An Information Sheet was published by the Office of Building, Department of Planning and Development, in September 1995 for the promotion of improved building standards for buildings owned by the Crown and public authorities. Its principal objectives were to:

- bring existing buildings to a safe standard fit to use and occupy; and
- bring public sector building standards into compliance with private sector building standards by the year 2000.

On risks to health and safety, the Standards Commentary stated:

The identification of an immediate risk to health or safety should receive urgent attention. Issues of critical concern to health and safety need early identification and rectification within a maximum of 12 months. Other important requirements should then be addressed within 5 years.

Further, the commentary advised that:

New publicly-owned buildings

All new buildings are required to conform with the Act and the Regulations. A new building is one that commenced construction on or after 1 July 1994.

Existing publicly-owned buildings

Existing publicly-owned buildings are to be brought up to a standard such that they are safe and fit to occupy in an acceptable time frame.

An 'acceptable time frame' depends upon whether a building is defined as core or non-core:

Core buildings are those which are essential to the ongoing provision of government services. The Guideline fosters full compliance with the Act and the Regulations as the minimum requirement.

The period taken to achieve compliance with the Act should be as short as practicable, and will depend on issues such as the particular building size, complexity, role, function and utilisation, as well as budget availability and investment considerations. In large building portfolios, a staged approach to the actions needed to achieve compliance may be required. ...

6 Exhibit 298 – Guideline 2 (emphasis added).

The identification of an immediate risk to health or safety should receive urgent attention. Issues of critical concern to health and safety need early identification and rectification within a maximum of 12 months. Other important requirements should then be addressed within five years.

In addition, on Guideline 3, the Standards Commentary stated:

BUILDINGS TO BE MAINTAINED IN A SAFE AND SERVICEABLE CONDITION

Agencies need to have in place, or to demonstrate they are endeavouring to put in place, adequate processes to identify and ensure that all buildings are safe and fit to occupy, and that all buildings are being maintained in a serviceable condition.

Agencies need to undertake rigorous condition assessments to meet the Act, other legislative requirements and also to satisfy government asset management expectations.

There was a clear intention for existing government buildings to be brought up to a safe standard fit for occupation.

In the context of the problems seen during this inquest, work on improvement in the area of building law requirements is continuing. The comment of counsel for ULA is very supportive:

The most recent bill dealing with fire safety standards in Government buildings is the Building (Further Amendment) Bill 1997. Clause 19 of the Bill when enacted renders the Crown subject to Parts 2-5, 7-11, 12A and section 201 of the Building Act 1993. This is an important advance with for the first time building permit procedures, building work inspection, and occupancy permit requirements to be made applicable to Government building work.

It would appear that general exemptions for departments, their agencies and public authorities including local councils will now be removed so recognising that fire safety standards should be universal and a high priority across public and private sectors. The changes also recognise that Government building exemption has not benefited the community but has led to serious departures from acceptable fire safety standards.[7]

The building work and the upgrade of the fire safety system to Building 37 at KRS must be seen in the context of these significant changes. To the credit of those responsible, many of the changes were well in place before the fire on 8 April 1996. Others were underway.

5.1.3 EXPERTS' VIEWS: A PROBLEM OF CLASSIFICATION

In order to ascertain the appropriate fire protection and safety systems applicable to a particular building, it has to be classified under the provisions of the Building Code of Australia. Classification will depend on the building's use and the nature of its residents.

The Gardner Group were engaged as consultants for the upgrade project following the 1994 Umow Lai Audit. During the inquest, Gardner also provided a lengthy overview of the building regulations and level of compliance for Building 37. In their conclusion, Gardner submitted that KRS Management and the Department of Health and Community Services *'generally appear to have satisfied statutory obligations with regard to retrospective compliance of buildings'*. Specifically, the Gardner report identifies the most appropriate classification as resembling 9A and points to a number of areas where compliance was satisfied:

7 ULA Submission, p. 16, paras. 2.31-2.32.

- No statutory requirement to comply with building regulations until 1988;
- No significant structural alterations occurred which may have required retrospective application of the regulations;
- For the 1993 alterations the provisions of Regulation 56.2 were deemed not to apply to the building not withstanding some upgrading of fire compartmentation;
- Appropriate consideration given to permit partial compliance pursuant to Regulation 5.7(4) for works to be undertaken as a part of the fire safety audit; and
- The certification issued by ASLAR in 1995 under the building regulations would have required the relevant or certifying building surveyor to consider issues related to regulatory compliance.[8]

By comparison, the MFB Report considers that the appropriate classification under the Code for Building 37 to be Class 3.[9] The MFB's building surveyor, Mr Marsicvetere, classified the building as a Class 3. The report of Peter Luzinat & Associates also classified Unit 30/31 as Class 3.

The Warrington Report is helpful in dealing with the issues associated with the Regulations and the Code. The report comments that '*there have been conflicting views expressed as to the classification of the building'* and '*[t]he criteria nominated by the BCA does not address issues specific to the type of occupancy and facilities such as Kew Cottages do not sit easily within either the Class 3 or Class 9a categories'*.[10] In a more strongly worded conclusion, Warrington is of the view:

> *11.2 Current building regulations and the technical provisions within the Building Code of Australia are inadequate for facilities such as Kew Residential Services. The adoption of the BCA 1996 and the proposed amendments to the Victorian Building Regulations will address some of the major limitations.*[11]

5.1.4 EXPERTS' VIEWS: FIRE SAFETY AND BUILDING REQUIREMENTS AT KRS

The Warrington Report concludes that the fire risk assessment undertaken by DHS to identify fire safety upgrades on the basis of engineering principles rather than strict compliance with regulatory requirements was appropriate. This method of assessment '*was consistent with performance based BCA which was launched in October 1996*'. Warrington is also of the view that:

> *9.5 Based on the MFB demonstration test the addressable detection system with local alarm sounders would have provided the opportunity for the clients to have been evacuated.*
>
> *9.6 The residential sprinkler system provides additional protection in case of failure of the detection system or the occurrence of a more rapidly growing fire, or problems with the evacuation.*
>
> *9.7 If either of the above measures had been in operation at the time of the fire it is likely that the loss of life would have been eliminated or substantially reduced.*[12]

Not only is the report of the view that addressable detection and sprinkler systems would have resulted in a better outcome but that the 1994 audit to fire engineering principles follows the new performance-based Building Code.

8 Exhibit 285, p. 14.

9 MFB Report, p. 136 et seq; see also p. 173.

10 Exhibit 201, p. 27.

11 Exhibit 201, p. 30.

12 Exhibit 201, p. 27.

Warrington understands that legislation is being proposed to require the fitting of residential sprinkler systems to accommodation units such as KRS within the next five years. Also proposed building regulations would not discriminate between Crown and privately owned land. In relation to future improvements, the report also comments:

> *9.11 It is also noted that the limitations with the existing BCA have been partially addressed by the release of a performance based BCA and will be further addressed by amendments to planned modifications to the Victorian Building Regulations to be implemented in 1997 providing additional requirements for facilities similar to Kew Cottages.*[13]

However, the Warrington Report cautions that:

> *9.12 The planned modifications to the building regulations will not address more subtle design considerations for fire safety such as fire prevention through the use of flame retardants, simple building layouts to facility ready evacuation and well illuminated sheltered assembly points for evacuation, and may not address the limitations of the current classification system.*[14]

Warrington considers that variations from the class 9A provision of the Building Code of Australia were identified by both the MFB and Gardner. While the 9A class does not specifically retrospectively apply to KRS, *'they form the most obvious guide to achieving a reasonable level of safety for building owners/operators to adopt'*. Warrington summarises the variations (at KRS) as identified from the class 9A type to include compartmentation; fire hose reels; smoke and fire detection system; alarm system/EWIS system; early fire hazard indices for linings; and egress provisions. As to the effect of the large number of variations in general, Warrington states that *'these did not contribute to the fatalities which occurred on the 8 April 1996. However under other circumstances they could critically have affected the outcomes'*.[15]

On compartmentation, the Warrington Report describes the location of the barriers as being *'smoke wall 1, in Flat B, smoke wall 2 in Flat C and a fire wall separating Flat B from Flats C and E'*. The positions of the three barriers were identified from 1993 drawings certified by Mr Russell Fogerty. Evidently, smoke wall 1 showed no evidence of deterioration or exposure to temperatures. Although the doors in the wall were not fitted with self closers, there was no significant smoke spread beyond the wall. Examination of the fire wall between Flats E and C showed it to be constructed in excess of the requirement under the Code (which is 60/60/60 minimum). The wall was made of plasterboard which was attached either side of the timber studs and extended above ceiling level. It was damaged in the fire which:

> *could have been caused by collapse of the roof which was not required to be fire resistant under the BCA. The BCA does not generally take account of the interaction of non-fire rated roofs with fire resistant walls in this type of construction. Observations indicated that the wall within the roof cavity had been subjected to significant fire exposure.*
>
> *8.2.9 There was little damage beyond the fire wall in the ceiling cavity beyond Flat E, and therefore it has been concluded that the wall above ceiling level retarded the spread of fire and smoke and any deficiencies did not affect the outcome on the 8 April 1996.*[16]

The door from Flat E remained substantially intact which assisted in preventing the further spread of fire. Warrington does comment on the fact that the fire wall had a glazed door and open roller

13 Exhibit 201, p. 28.

14 Exhibit 201, p. 28.

15 Exhibit 201, p. 30.

16 Exhibit 201, p. 23.

shutter. This resulted in the spread of smoke into the kitchen area. However, the building's general construction and MFB intervention restricted flame spread.

Smoke wall 2 could not be identified after the fire. Warrington opines that it had not been constructed above ceiling level because *'evidence of flame spread beyond its proposed location implies that it was not provided'*. Evidently, there were no smoke doors positioned as indicated in the 1993 drawings but non-self closing doors were provided four metres down the corridor towards Flat D. Warrington comments:

> *8.2.16 Substantial smoke spread down the corridor towards Flat D via the open doors did occur. However the satisfactory evacuation of Flat D residents was achieved by the staff and therefore the state of the smoke wall does not appear to have significantly affected the outcome of the fire.*[17]

On the non-provision of 'hose reels', Warrington considers that, because of the extent of development of the fire when staff arrived, reels would have been unlikely to have assisted manual suppression. In the event that suppression had been attempted by staff, the evacuation of clients would have been delayed. Further, the report concludes that the MFB would have tended to rely on their own equipment. On this issue, Warrington concludes that '*variations from the BCA provisions for hose reels would not have significantly affected the outcomes*'.[18]

With early detection and alarm, Warrington concludes that '*there would have been a high probability of a safe evacuation of all the occupants if the fire had been similar to the MFB demonstration test and the system had operated successfully'*. However, with a delayed response (either resulting from a failure of the detection system or the use of thermals), an outcome similar to 8 April 1996 could be expected. Because of difficulties with ascertaining the extent of noncompliance of the detection/alarm system, the Warrington Report cannot reach a conclusion on this issue.[19]

Under 'Early Fire Hazard Indices',[20] Warrington comments that the prescription in the Code is intended to control hazards associated with use of combustible lining materials. It is noted that while the drawings prescribe ¾ height plasterboard partitions full height MDF was used. The MDF lining did not meet the Early Fire Hazard Indices *'prescribed for patient care areas in class 9A buildings but based on the available data did comply with the requirements for non-patient care areas'*. However, during the MFB fire test, the MDF did not become involved until the fire approached flashover. Also the full height walls between bedrooms did not burn through until 20 minutes after start of the fire test. Warrington concludes that although '*under some circumstances combustible linings can become involved early in a fire scenario* [but] *the MFB demonstration test showed this not to have been the case at Kew Cottages'*.

Apparently, the 'Egress Provisions' did not meet the requirements of the Code because:

- *some doors swing against the path of travel to an exit*
- *the security provisions mean that the exit doors cannot be opened by a single action*
- *there are a number of dead ends with travel distances greater than the nominated minimums to a point of travel in two directions.*[21]

However, the report concludes that the requirements of the Code do not address the special needs of facilities such as KRS. Warrington examines the position of the doors in the area of Flat E (in

17 Exhibit 201, p. 24.

18 Exhibit 201, p. 24, para. 8.3.3.

19 See further discussion in the Findings in **Part 4 Survival and the Detection System on 8 April 1996 4.1 State of the Fire Alarm System on 8 April 1996.**

20 Exhibit 201, p. 25, para. 8.5.

21 Exhibit 201, p. 25, para. 8.6.1.

particular, doors 1, 6 and 7). Door 1 opened inwards (the writer was not clear as to whether it was unlocked), and door 7 was probably open at the time of the fire. The report makes the point that:

> *[i]n general the swing of doors against the direction of flow could slow evacuation but such deficiencies can be compensated for by enhancements in other fire safety systems, but do not appear to be relevant to the outcomes on the 8 April.*[22]

According to the Warrington Report, dead ends can create severe problems and should be avoided. The report did not consider that the dead ends created a problem during the fire.

On security, Warrington highlights the conflict between fire safety and other risks. See the further discussion in the Findings in **Part 3 Management of Risk and System Deficiencies 3.12 Automatic Door Locking/Release Systems.**

5.2 ALTERATIONS TO BUILDING 37 (UNIT 31): EFFECT ON FIRE SAFETY

5.2.1 CONSTRUCTION OF BUILDING 37 AND UNIT 31

The MFB Report summarises the construction of Building 37 as being:

> *a single storey structure measuring 70 m x 20 m, located at the northern side of Lower Drive. Building 37 was constructed externally with brick veneer walls with a gable trussed roof, covered by asbestos cement corrugated sheets, spanning much of the structure. The newer sections, constructed in 1993, that comprised part of Flat "E" and Flat "B" were skillion roof covered by Klip-lok metal decking.*
>
> *The internal linings used throughout Building 37 varied considerably. This appears to be the result of several modifications and extensions carried out over the years.*
>
> *The walls were lined internally with a combination of Masonite sheet, masonry and Medium Density Fibre board (MDF) with the ceilings being lined with a combination of fibrous plaster, plaster board and composite board.*
>
> *The floor construction also varied with sections consisting of concrete whilst others were formed using timber. The floors throughout the building were covered with vinyl floor coverings.*
>
> *The windows throughout Building 37 were glazed with polycarbonate sheet of thicknesses varying between 4.5 mm and 6 mm thickness. The windows were also fixed with limit stops to restrict the distance by which they could be opened. The windows were covered with security aluminium shutters.*
>
> *Flat "E" consisted of three bedrooms. Two bedrooms were located on the north side of the unit at the western end (the western most being bedroom 2), and the third bedroom located on the southern side of the western end. A bathroom was located adjacent to the bedroom on the southern side of Flat "E" and a kitchen/living room was located in the northeast corner of Flat "E". All rooms were accessed via a hallway located centrally within the flat, running in an east west direction, and opening into the kitchen/livingroom area.*
>
> *The southern section of Flat "E" was constructed on a concrete floor (approximately 148.55 m2) whilst the northern section was constructed on a timber subfloor*

22 Exhibit 201, p. 26, para. 8.6.7.

(approximately 60.45 m2) consisting of 100 mm x 75 mm OB hardwood bearers, 100 mm x 50 mm OB hardwood joists with 19 mm thick 900 mm x 3600 mm yellow tongue sheet flooring.

The walls were constructed with 90 mm x 35 mm F7 pine studs lined internally with 12 mm thick 1200 x 2400 MDF sheets. The roof section above Flat "E" was a combination of gable truss (over the southern section) and 250 mm x 50 mm F7 oregon rafters (@ 600 mm centres covered by Galvanised Klip-lok roof deck (over the northern section)).

The ceilings were lined with 10 mm plasterboard with 65 mm quad cornice. The windows were glazed with polycarbonate sheeting with limit stops attached to the windows to limit the distance by which they could be opened. The windows were covered externally with security aluminium shutters.[23]

5.2.2 ALTERATIONS AND CERTIFICATION AS AFFECTING FIRE SAFETY IN BUILDING 37

(1) INTRODUCTION

The 1994 ULA Report examines the construction of the then existing buildings and emphasises that '*[u]pgrades of buildings should be referred to a professional fire protection engineer to ensure that there are no inadvertent consequences for fire safety of building fit out or furniture selection decisions'*.[24] Earlier, the Lumley Report effectively made the same point:

> *Subsequent changes may occur, can therefore substantially alter the nature or degree of exposure of a risk and as a consequence, thereby invalidate the present control recommendations. These factors must be considered when corrective action is being planned towards implementing our advisory recommendations.*

The 1993 Dibben Report (which was not seen by KRS management) deals with the importance of building structure as it relates to fire safety, saying '*many buildings have two separate units ... although efficient operationally, this creates massive conflict and problems from a fire safety point of view'*. Dibben also makes the point that most sleeping areas accommodate 20 or more people with '*no fire (or smoke) separation within the sleeping areas'*. Further, it is said that:

> *[n]o fire separation, ground level or roof void, exists between units in any single building. This is contrary to sound accepted practice and well outside any objectives of the BCA.*[25]

With regard to Building 3, Dibben comments that:

> *it is the only building that meets BCA requirements. This building has been gutted and rebuilt to acceptable standards of separation between rooms and occupancies, has an appropriate detection system and alarm system. Fire extinguishers and hose reels provide reasonable cover if someone is available to fight a fire.*[26]

The original documentation for the 1994 audit – *'Kew Training Centre Fire Safety Upgrade – Consultant Brief, Fire Audit and Schematic Design'* – established that the objective of

23 MFB Report, p. 29.

24 Exhibit 143 – ULA Report.

25 Exhibit 54 – Dibben Report, p. 4.

26 Exhibit 54 – Dibben Report, p. 4.

the project was to *'bring the Fire Safety level of Kew Training Centre up to a reasonable level that will be acceptable to the Training Centre, Department of Health and Community Services and the certifying Building Surveyor'*.[27]

Irrespective of the 'Ministerial Guidelines' for safety in public buildings, there existed sufficient documentary material and knowledge within both KRS and DHS of the importance of adequately addressing fire safety when undertaking major renovations to Building 37.

A building surveyor was engaged by KRS in May 1995 to certify the plans, but ULA was neither consulted nor advised about the 1995 renovations to Unit 31. In spite of clear advice in the ULA Report, no fire engineer was retained or consulted on the upgrade or choice of materials. Apparently, ULA had completed the overall design work for the KRS site by May 1995 but was unaware of the renovations to Unit 31 until 31 October 1995. At that stage the Project Control Group requested a redesign of fire safety works to the renovated unit. ULA was then brought into the process. During the period of the renovation, the residents were relocated for about six months and the unit was vacant. Unfortunately, an opportunity to install a new fire safety system while renovations were underway was lost.

The renovations to Unit 31 were undertaken between May and November 1995. The works included:

- conversion of three bedrooms into a kitchen/living area, and bathroom;
- renovation of two bathrooms;
- removal of a wall to create a kitchen/living area;
- relocation of bedroom door 9 from the northern to the southern wall; and
- creation of bedrooms in Flats C and D.[28]

While the renovations were being undertaken, some smoke detectors were replaced by Jonkar. However, a fire safety plan was not prepared.[29] The building retained the reported 'inadequate' fire safety system until the fire.[30]

In breach of the Ministerial guidelines, no inspection was undertaken during or after the renovation works conducted over the period May-November 1995. As a result, the deficiencies in the fire safety system were not identified or remedied.

(2) KRS'S APPROACH TO RENOVATIONS AND RISK

As already indicated, the ULA Report emphasised that:

> *[u]pgrades of buildings should be referred to a professional fire protection engineer to ensure that there are no inadvertent consequences for fire safety of building fit out or furniture selection decisions.*[31]

An examination of the approach by those responsible at KRS for the renovation of Unit 31 and the fire risk is essential in determining the role of Mr Vincent Paino, the building surveyor. Such examination also highlights problems with managing the risk at KRS.

In giving evidence on 10 February 1997, Mr Lai deposed that he was not aware of the renovations in Unit 31 until the end of October 1995. The transcript reads as follows:

27 Exhibit 162, para. 2.2 (emphasis added).

28 Exhibit 176 – Mr Vasan's statement, pp. 7-8; Transcript, pp. 6011-6012.

29 Transcript, p. 6022.

30 See the Lumley, Dibben and ULA reports and the Fabric Survey.

31 Exhibit 143 – ULA Report.

Mr Hicks: You indicated to Mr Redlich that you were aware that there was from time to time, for want of a better expression, refurbishing going on at some units, during the fire upgrade?

Answer: To my recollection I can recall Unit 4 being refurbished.

Question: I think you indicated, Mr Redlich, Units 30 and 31, December of 1995, being refurbished.

Answer: Yes, we found that I believe, about 30 October/1 November.

Question: Whilst you didn't have the supervisory role as far as the staff training was concerned, as I understand it, you accept there was some supervisory role as far as the installation of a fire safety system?

Answer: Yes, we carry out technical inspections of the installation.

Question: Were you ever consulted or asked to advise, about these refurbishments in terms of fire safety?

Answer: No, we were not.

Question: Were you provided with plans or notices that this refurbishment was going to take place?

Answer: No, we were not.[32]

In a statement in reply, Mr Lai reiterates his recommendation in Appendix X to the fire audit. When examining his comments on the 'Refurbishment of Unit 31', the significance for risk management becomes obvious:

36. When unit 31 was refurbished in 1995, ULA was not consulted or advised of the proposed works. I was unaware that refurbishment work was being undertaken to this unit until 31 October 1995 when a request was made at a PCG meeting for the completion of a redesign of fire safety works to unit 31.

37. If previous advice of the proposed conduct of refurbishment work unit 31 had been possible, consideration would have been given to the installation of fire safety systems as part of the proposed refurbishment work. Now produced to me and marked document D3 is a copy of a letter dated 1 November 1995 from ULA to John Taylor.[33]

The letter, signed by David Uhlhorn, states:

Further to our professional fee proposal 30th October 1995, we have been advised that Unit 31 has also undergone replanning and refurbishment requiring redesign of the fire service. Our fee for redesign and documentation of this unit is $720.00, which with the works previously advised brings our fee proposal to the lump sum total of $6,360.00.

We trust our proposal will meet with your favourable consideration, and await your further actions.[34]

It would appear that ULA's fee proposal just two days prior does not include an account for reworking of the documentation for Unit 31. The earlier letter (also signed by Uhlhorn) dated 30 October deals with Smorgon, Geiger, Units 5 and 29, and commences: '*Thank you for your invitation to submit our professional proposal for additional professional engineering services on this project'*, and in effect refers to '*preparation of design and documentation for fire detection, fire sprinkler*

32 Transcript, pp. 3602-3603.

33 Exhibit 224, pp. 9-10.

34 Exhibit 224 D3 – a copy was sent to Mr J. Bentevoglio, CMB.

and exit signage systems for each building'. The documentation was prepared as a variation to the Wormald Fire Systems contract.[35] On the face of it this appears supportive of Lai's evidence that he was unaware of the renovations until late October. In addition, even though ULA is obviously aware of renovations to other units, Unit 31 is not included. However, against this, there is no PCG meeting on 31 October. The nearest meetings to that date are on 13 September and 8 November. Further, there is a memorandum to Bruce Hoskin of Wormald from David Uhlhorn of ULA, dated 1 December, which says:

> *As discussed at the last site meeting, Units 5, 29 & 31 are to be redocumented due to changes in internal fitout subsequent to the preparation of tender documents – Your submission of fire sprinkler drawing F30 & 31 cannot therefore be approved.*[36]

On the issue of renovation, Unit 31 is first directly referred to in minutes of the PCG Meeting No. 4 (20 December 1995) under 'Minutes of Previous Meeting – Matters Arising':

> *3.3.1. John Bentivoglio requested additional information on the scope of new work proposed for the Fire Alarm and Detection contract. This was then given at the meeting as:*
>
> *Revised scopes of work will be required for Units 2, 5, 6, 10, 29, 31, Geiger and Smorgon Centres.*[37]

The minutes noted that *'[a]dditional funds ($69,360.00) were sought and have been approved'*. The total was made up of *'[t]he estimated scope of the new work ... $63,000.00' and 'Consultant documentation fees... $6,360.00'*.[38]

An inspection of ULA's files disclose plans being drawn for Unit 31 after Uhlhorn's letter dated 1 November 1995. There are no significant references in the file to Unit 31 on the issue of renovation before this date.

At the PCG meeting of 26 January 1995, at which Messrs Taylor and Vasan were present, renovations to units were marked as being discussed under item 4 'Project Procurement Method'. Notes on ULA's minutes show:

> *Unit 4 is partially complete*
>
> *Unit 28 – is happening*
>
> *Unit 29 and 5 are bracketed as for 'next financial year.*[39]

There is no mention of proposed renovations to Unit 31.

On 20 March 1997, Mr Taylor was asked some questions on this issue by Mr Osborn:

> *Mr Osborn: Did it occur to you that it might have been possible to put in fire protection works in Flat E, in the course of the renovation?*
>
> *Answer: The second renovation do you?*
>
> *Question: Yes?*
>
> *Answer: No, we gave the plan to Umow Lai and expected that they would review the design, and would ultimately upgrade it with the – with the total project. ...*

35 Exhibit 169, pp. 88-89.

36 Exhibit 169, p. 63.

37 Exhibit 170 – Minutes 20/12/95 (emphasis added). NOTE: Unit 31 is specifically referred to in the PCG minutes of 15/8/95 in relation to asbestos removal.

38 Exhibit 170 – Minutes 20/12/95.

39 Exhibit 169, p. 58.

Question: When you come back to the building, in '95, wouldn't you have expected to ensure that following the renovations there was a professional assessment of whether it wouldn't be convenient to improve the fire protection system at that time?

Answer: Well we – we raised it at the PCG and it was never put to us, at that time, that that was an option or a way to go.[40]

Later during evidence both Messrs Vasan and Taylor were questioned about this issue. The evidence is detailed, and much of it is necessary in order to understand some of what was happening at KRS during this time. When the issue of the letter dated 1 November was put to Mr Taylor, he responded:

Answer: ... Yes. I put it to them at a PCG that they'd overlooked my previous advice some time well before that that we were doing renovations there, and I take it that's a confirmation of that.

Question: Mr Taylor, if you want a fire engineer to do a design for you you know what to do, don't you?

Answer: Well, you'd what –

Question: This was the first quote ever received for that work, wasn't it ?

Answer: No, I don't believe it is. I believe we have another letter prior to that date indicating that there are re-designed fees for three buildings, as well as a range of other works that had been additional to the – to their contract.

Question: Mr Taylor, Mr Lai was not prior to November 1995 retained to provide you with a fire safety design for Unit 31, was he?

Answer: Well. I'm just saying what my answer is.[41]

The reference to '*another letter prior to that date'* may well relate to the letter dated 30 October from Uhlhorn, which does not refer to Unit 31. It seems unlikely that Wormald would be permitted to work on plans relating to Unit 31 when the Principal Consultant – ULA – knew they would have to be changed because of renovations.

In order to assess the issues surrounding the changes to Unit 31 in 1995, it is necessary to further examine the evidence of Messrs Taylor and Vasan. In the process of assessing the evidence, it is noted that both Vasan and Taylor were KRS's representatives on the PCG. Taylor regularly attended meetings; Vasan was not as regular. However, both had considerable corporate knowledge about the history of the upgrade. Both could reasonably be said to share some of the commendation for the moves towards improvements in fire safety at KRS.

Detailed evidence about the renovation issue was first given by Mr Vasan. Significantly, when questioned on the issue of the building surveyor's certificate (before Mr Paino was involved in the inquest), the following exchange took place:

Question: Yes, I see; well, when this major upgrade of Unit 31 occurred what work was done to the fire services?

Answer: Existing system – basically, the existing system remained.

Question: Are you saying that the building surveyor who certified the upgrade of Unit 31 had no requirement in relation to fire systems?

Answer: That's my understanding, yes.

40 Transcript, p. 5363.

41 Transcript, pp. 6040-6041.

Question: You would agree that when a building is constructed or significantly altered it is a standard requirement for the Fire Safety Standards of that building to be brought up to proper levels?

Answer: I remember this was discussed and there is also a Section 562, if I remember right, was mentioned that if the renovations don't exceed a certain percentage the existing Standard is (indistinct), or something like that.

Question: Are you saying there was a discussion about the exemption of the work carried out to Building 31 from the requirement to bring it up to date in terms of its fire safety level?

Answer: That's correct, yes.

Question: Who did you have that discussion with?

Answer: With my manager.

Question: Who is your manager that is Mr Taylor, is it?

– (Inaudible response)

Question: What did the two of you decide?

Answer: No, we haven't decided, as such, but we said: "Yes, it's approved; basically, we can go ahead and do that."

Question: He approved the performance of the building works to Unit 31 without any fire safety works being undertaken?

Answer: Well, that's what is in the certificate, yes. That's not been approved, yes.

Question: [Apparently] We had occurring a major renovation going on to Unit 31 without any work at all being done in relation to the fire safety requirements of that building?

Answer: That's what – I didn't call it major – I still call it a minor upgrade, really.[42]

It is noted that the transcript records Mr Vasan as referring to 'Section 562'. Apparently, he is referring to section 56.2 of the Victorian Building Regulations 1983. Section 56.2 applied to the renovations to Unit 30 in 1993. However, a new regulation 5.7 under the Building Regulations 1994 applied to the 1995 renovations to Unit 31. The evidence continues:

Question: Was any consideration given in the course of this upgrade to Unit 31 to the preparation of a fire safety plan for the building?

Answer: We have – Umow Lai and all on site, and they were there, so we know it's going to happen many times.

Question: But you didn't ask Umow Lai to prepare a fire plan in relation to Unit 31, did you?

Answer: We asked them to do a plan.

Question: Before you undertook the upgrade of works to Unit 31 you did not ask Umow Lai to prepare a fire plan for that building, did you?

Answer: No, not before (indistinct).

Question: In fact, you carried out the works and Umow Lai found out about it later, didn't they?

Answer: No, I am sure Umow Lai was told that there's work going on.

Question: Did you ask Umow Lai to prepare a fire plan for Building 31 before the work was done?

42 Transcript, pp. 6013-6014.

Answer: Not before the work was done.

Question: Did you have an architect retained in relation to those renovation works for Unit 31?

Answer: Yes.

Question: Did you ask the architect to prepare a fire safety plan for that building?

Answer: I thought the architect has done it that is why I sent the s.562.

Question: Who was your architect who had done that?

Answer: ProArk Limited.

Question: Did they prepare a fire safety plan for Unit 31 before the upgrade of the building occurred?

Answer: No, not that I can recall.

Question: Did you retain an engineer to give you advice as to what fire safety steps were to be put into operation before Unit 31 was upgraded?

Answer: No, we didn't.

Question: So is the position this, Mr Vasan, that the works that were undertaken to Unit 31 over the period leading up to October 1995 were undertaken without any plans of the fire safety requirements of that building?

Answer: That is what I said before that there was a certificate given saying that s.562 can't be enforced, so that means we don't have to (indistinct) fire safety provisions apply, or (indistinct).[43]

Mr Vasan appears understandably mistaken on the application of section 562. This would have applied to the earlier renovations to Unit 30 in 1993. Although Vasan had no training in the area of building approvals, from a reading of the transcript, it appears that he had some understanding of the process. Further, although equivocal on the issue of ULA being told before the renovations, he is in no doubt that the engineer was not involved for fire safety advice prior to completion of the renovations. Vasan clearly regards the work as 'minor'.

Mr Vasan's understanding of the fire safety system following the renovations is best summarised in the following exchange:

Question: At the completion of those works in October 1995, were you, yourself, satisfied with the fire safety standards that were operative in that unit?

Answer: It was the same system operating in the rest of the building, or the rest of the complex, and same standard, same system operating everywhere.[44]

The next exchange indicates that, at least, Mr Vasan knew the fire system was inadequate after the renovations. This is in spite of the building certification system:

Question: Mr Vasan, you would be aware, I assume, that if you want to put an extra room on your house in our community, you need a building permit to do that?

Answer: That is correct.

Question: And to get a building permit it will be necessary to obtain certification by a building surveyor, amongst other things, relating to the fire safety standard of your developments?

Answer: We had the certification from the building survey as to that.

43 Transcript, pp. 6015-6016.

44 Transcript, p. 6016.

Question: The certification that you had was an exemption?

Answer: And as to all of the plan.

Question: You were conscious, were you, as the works were proceeding, that the building when completed, in accordance with those works, would not meet acceptable fire safety standards?

Answer: Yes, at that time, but we know we are going to do the upgrade within months, so it should have been done at that time.

Question: So although there was a risk that the building would be completed and used, you were happy as it were to accept that risk?

Mr Redlich: I object to that, Your Worship. I trust my friend appreciates that the residents were not occupying the building during the period of the renovations and that prior to –

Coroner: But presumably they were to occupy the building after the renovations?

Mr Redlich: Correct; ... .[45]

As already noted, Mr Taylor, the Facilities and Services Manager, was earlier questioned on a number of these issues. His evidence discloses a different emphasis:

Question: Did it occur to you that it might have been possible to put in fire protection works in Flat E, in the course of the renovation?

Answer: The second renovation do you – – –?

Question: Yes?

Answer: No, we gave the plan to Umow Lai and expected that they would review the design, and would ultimately upgrade it with the – with the total project. ...

Question: When you come back to the building, in '95, wouldn't you have expected to ensure that following the renovations there was a professional assessment of whether it was convenient to improve the fire protection system at that time?

Answer: Well we – we raised it at the PCG and it was never put to us, at that time, that that was an option or a way to go.[46]

On Mr Taylor's view of his responsibilities, he stated in evidence:

Question: Do you agree, Mr Taylor, as an experienced facilities manager, that when building works are undertaken, it is good practice to ensure that those works are completed in accordance with proper fire safety standards?

Answer: Yes.

For an understanding of the context in which this view is held, the evidence must continue:

Question: When the works that were carried out to Unit 31 were prepared, was there any design of what was to be done that was completed?

Answer: I'm sorry, I can't – –

Question: I'll put it to you this way: when the works that were carried out to Unit number 31 were undertaken, had there been any plan or design for those works prepared?

Answer: Yes.

Question: Who had prepared the plan for those works?

Answer: Our architect.

45 Transcript, pp. 6016-6017.

46 Transcript, p. 5363 on 20/3/1997.

Question: Did the architect address fire safety matters?

Answer: No.

Question: You would be aware, Mr Taylor, in the course of your experience, that it is normal, if not mandatory practice, for the architect to address fire safety aspects of building works?

Answer: The building works that we were undertaking were of a very minor nature. They – they didn't extend beyond the normal boundaries of the existing building. We – with discussions with our architect were aware that we had a fire – major fire upgrade about to occur, and all of those issues would have been addressed at the major upgrade.

Question: Wasn't the performance of works to Unit 31 an obvious opportunity to achieve a fire safety upgrade of that Unit?

Answer: Well, Dominic (Lai) never made that point, and he never – I certainly didn't perceive it was a possibility to install the system ahead of the system, because of the looping and water mains and all of those things which would've had to have been run with major upgrade.

Question: When you say Dominic never made that point, Mr Taylor, are you conscious of what he says in his guidelines for building refurbishment.[47]

Mr Taylor states that '*Dominic'* never made the point regarding the opportunity to upgrade during the 1995 renovations. In re-examination by senior counsel for the State of Victoria, Taylor leaves a different impression as to the conversations held with ULA representatives:

Mr Redlich: You were asked some questions by Mr Garde about the correspondence passing between Umow Lai and yourself at the beginning of November 1995 concerning a request that Umow Lai provide a re – design plan for the renovated Flat E; you recall that?

Answer: Yes.

Question: You made mention in the course of your cross-examination of conversations that you believe you had with representatives of Umow Lai about the renovations?

Answer: Yes.

Question: Who do you recall speaking with?

Answer: I thought it was with Mr Ulhorn, actually.

Question: Mr Ulhorn?

Answer: Yes.

Question: Approximately when did you have those discussions?

Answer: I can't actually recall the exact time, but I would have thought some months prior to the October date.

Question: What was the substance of the discussions?

Answer: I advised him that we were, although the plans had already been done, and they had gone out to tender, that there were going to be some minor changes to Unit 31 and that 5 and 29 would need to be resigned when those plans were ready.[48]

Apparently, the conversation was with Mr Uhlhorn, not Lai, as was put in Mr Taylor's earlier evidence. Mr Uhlhorn has not been called.

It is noted, in all of the questioning on the renovations, that Mr Taylor views the works as being of a 'minor' nature:

47 Transcript, pp. 6038-6039.

48 Transcript, pp. 6281-6282.

Question: He wasn't specifically asked to do design work for Unit 31 until November, was he?

Answer: No, prior to that. He had already done his design work for Unit 31 back in June.

Question: Mr Taylor, is the position this, that you were conscious of the need for a fire safety design for Unit 31 in May 1995?

Answer: Sorry could you repeat that?

Question: Is the position that you as Facilities Services Manager, were conscious of the need for a fire safety design for building works for Unit 31 in May of 1995?

Answer: No. At that time we were simply – there was – there was – there was no extension in the building – my recollection there'd be – there'd be simply the – the one thing that Mr Vasan got done by our fire contractor was to replace some smoke detectors with thermals in kitchens, and that was the extent of the work. It was very minor in nature.[49]

The extent of the fire safety modifications following the work may provide a clue as to the view that the works were 'minor':

Mr Garde: Now you as a facilities manager would know that it is a normal ingredient of building work that fire safety measures be addressed as part and parcel of that building work?

Answer: ... [T]hat is why we had Jonkar – there was only one detector involved in that work, and that is why we had Jonkar look at it.

Mr Garde: So you had Jonkar, a contractor, do some fire upgrade work?

Answer: Whatever was necessary to bring the system in line with the rest.

Question: Before you directed Jonkar to do some work, did you cast your mind to the need for a fire services plan for the unit to be prepared before work was undertaken?

Answer: We knew that was coming with Dominic, because he was on site.[50]

In this section of the transcript, Taylor reiterates that ULA had prior knowledge of the renovations. However, he had also read the ULA Report and was aware of its recommendations:

Mr Garde: What I ask you, Mr Taylor, is when the works were undertaken in, the course of 1995 to upgrade and change Unit 31 was consideration given to the fire safety requirements that might arise as a result of the upgrade?

Answer: This is exactly the time that the renovations were taking place in 31 and I had flagged it much prior to this date with Umow Lai that they would be occurring, and at no stage did they suggest to me that that was an appropriate thing that should occur prior to the major upgrade.

Question: But you were conscious, were you not, that the ministerial directive had to be complied with when any renovation or upgrade of buildings occurred?

Answer: Given we had fire engineers already on site, already working on plans, it seemed to me a practical and sensible thing to pay the people who should be handling it.

Question: Why didn't you request them before the work was done to Unit 31 to give you a fire plan for Unit 31?

Answer: They never suggested it to me that it was an appropriate thing to do.

Question: Mr Taylor, did you read Mr Lai's report?

49 Transcript, p. 6046.

50 Transcript, pp. 6055-6056.

Answer: Yes.

Question: Did you read the section that deals with guidelines for building refurbishment?

Answer: Yes.

Question: Did you read what was put as to how building refurbishment ought to be undertaken?

Answer: Yes.

Question: You would have received this document eight or nine months before that work actually started on Unit 31?

Answer: Yes.

Question: And were you conscious of a recommendation that upgrades of buildings should be referred to a professional fire protection engineer to ensure that there are no inadvertent consequences for fire safety and building fit out or furniture selection decisions?

Answer: I can only repeat that we gave him the drawings of five buildings – three buildings that were being currently planned and for which 31 was one of them, and that was his reaction to us.

Question: Was it thought that money would be saved in relation to the upgrade of Unit 31 by not getting expert advice on fire matters?

Answer: No.

Question: You have been the facilities manager, as I understand it, at Kew for a significant number of years?

Answer: Yes.

Question: You would have, of necessity, I take it, been involved in many changes and works to public buildings over that period?

Answer: Minor works, yes.

Question: Well, you will be conscious that the revision of proper fire safety standards is an integral component of building works?

Answer: During this period we – we had audits and fire engineers on the site almost continuously and I guess we had in our mind that the upgrades were being designed and looked at that time.

Question: Mr Taylor, you would agree that it is proper practice for a facilities manager who is undertaking building works on behalf of the State to ensure that when those works are completed, they attain an appropriate fire safety standard?[51]

The question whether there was any difficulty in the early upgrade of fire safety in Unit 31 was considered:

Mr Garde: Mr Taylor, you don't suggest that there was any difficulty with carrying out a fire safety upgrade of Unit 31, do you?

Answer: At what time?

Question: In 1995?

Answer: There's no difficulty.

Question: No, it's simply a matter of working out what you want, getting it approved, and then doing it?

51 Transcript, pp. 6036-6037.

Answer: Yes.

Further questions on this issue were put to Taylor:

Question: ... [W]as there any reason why the fire upgrade of Unit 31 could not have been undertaken at the same time that the renovations and changes were effected from May of 1995?

Answer: Our decision was to – during the course of the initial stages of the renovations – to use our fire protection company to assess the appropriate placement of all detectors in the building that we were working in, and that we notified Dominic Lai some time prior to November that that is what we had done.

Coroner: You were using FFE?

Answer: We were using Jonkar.[52]

This issue was also discussed in re-examination when Mr Taylor considered that he did not have the required expertise to pass a judgement on an earlier upgrade:

Mr Redlich: ... Applying the common sense test that was urged on you last Friday do you see any way that you could have commenced to do an upgrade in Flat E before the time that it was known that Wormalds would be the contractor and their equipment would be used for the upgrade?

Answer: I don't think it was possible.

Question: We also know, do we not, that by October 1995 the renovations are almost completed in Flat E; is that so?

Answer: That is so.

Question: Are you able to express any opinion, Mr Taylor, or, more particularly, could you have during 1995 as to whether it was possible once the contractor was known and upgrade works commenced to do the loop for Building 37 first?

Answer: I wouldn't have known that.[53]

It is difficult to understand why ULA, if advised in advance of the proposed renovations to Unit 31, would not include that work in its costings and look to amending the already completed fire plans.[54] Apparently, it was doing this for other renovations to units at KRS prior to late October 1995. Commercially, it would make sense to put in an account for new work on being first advised. Accepting for a moment that ULA was advised of the 'minor' changes and that it took no action, it is difficult to understand why Mr Taylor, an experienced manager who had been a driving force towards the upgrade, did not recognise the potential for renovations to alter fire safety in the building. The fact that he had read ULA's recommendation renders the response more puzzling.

Ultimately, it is possible to say that ULA was not advised or formally required to look at renovations until any opportunity to integrate fire safety systems into its design was lost. It was a management issue in the context of established awareness of the inadequacy of the fire systems at KRS and for the building. Clearly, management may have been influenced by the view that the works were 'minor'. Unfortunately, the works were not as they required the unit to be vacated by the residents for a period of many weeks. The works divided the building into flats and were to significantly alter the living conditions for the residents.

There was an identified risk in returning the residents to a building that had inadequate fire safety systems. The issue of either incorporating the fire safety work into the renovations or leaving Unit 31 empty until the upgrade was completed appears not to have been considered. It should have been.

52 Transcript, pp. 6047, 6055.

53 Transcript, p. 6284. Mr Taylor had similar responses to questions about the loop and installation of addressable detectors.

54 The fire plans for the work on the upgrade for KRS were completed in May 1995. They were given to Wormald for quotation.

The management role is highlighted in the following exchange between counsel and Mr Taylor:

> *Question: Do you agree, Mr Taylor, as an experienced facilities manager, that when building works are undertaken, it is good practice to ensure that those works are completed in accordance with proper fire safety standards?*
>
> *Answer: Yes.*

But this answer must be seen in the context of many years of frustrating work to achieve a commendable result – the upgrading of the whole of the fire safety systems at KRS. Management had an understandable '*continuing lack of ... faith in the ageing system*'.[55] Again, Mr Taylor makes a relevant point:

> *During this period we – we had audits and fire engineers on the site almost continuously and I guess we had in our mind that the upgrades were being designed and looked at that time.*

Perhaps the truth of the timing rests with Mr Vasan's answer:

> *Question: You were conscious, were you, as the works were proceeding, that the building when completed, in accordance with those works, would not meet acceptable fire safety standards?*
>
> *Answer: Yes, at that time, but we know we are going to do the upgrade within months, so it should have been done at that time.*[56]

(3) LOST OPPORTUNITY TO RE-ENGINEER THE SYSTEM IN BUILDING 37

The involvement of a building surveyor presented an opportunity to bring the fire systems in Building 37 up to standard. There were on-site consultants at the complex dealing with the upgrade. It remains a puzzle as to why they were not involved. The argument made by the State of Victoria that effectively suggests that the system could not have been partially installed has been considered. It is not persuasive. At the minimum, even accepting that the State's argument is correct, there is all the more reason for not putting the residents back into an area of risk.

(4) ROLE OF THE BUILDING SURVEYOR

As the usual building surveyor – Mr Russell Fogerty – was unavailable, another surveyor – Mr Vincent Paino – was approached by Mr Vasan. The selection of Mr Paino appeared to result because of his proximity to Vasan's private residence. In evidence, Mr Vasan said of the selection of the building surveyor:

> *Question: And that Mr Paino was more conveniently located for you to be able to drop off any materials that needed to be?*
>
> *Answer: Yes, that's because I picked his name from the telephone directory and his address was Cape Street, and I live in Cape Street, also.*[57]

Mr Vasan was unable to contact Fogerty because of council amalgamations. He first approached Paino sometime between 3 and 10 May 1995.[58]

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55 Transcript, p. 5363.

56 Transcript, pp. 6016-6017.

57 Transcript, p. 7000. See also Exhibit 258.63 – Mr Paino's statement.

58 Exhibit 258.63 – Mr Paino's statement.

Mr Paino's company – Ashlar Building Services Pty Ltd – undertook the work. His company trades under the name 'Diamond Valley Building Surveyor Services'. Evidently, the work for KRS on Unit 31 was Paino's nineteenth job after having left Diamond Valley Council to start business on his own account. He had eight years of experience, and was most recently employed as a Deputy Building Surveyor. He was paid $100 for the work. He was also paid the same figure for certification of renovations to another building – O'Shea.

The architect's plans dated 25/4/95 (ProARK) for '6 Lower Drive' were certified by Ashlar with the note, '*doors and walls to bedrooms to have 1 hr fire rating*'.[59] A facsimile to Vasan dated 8 May 1995 states:

> *2. Door to bedroom to have 1 hr. fire rating (Drawing A3)*
>
> *3. Walls to infill door opening to bedroom and wall between bathroom and bedrooms to have 1 hr. fire rating.show on plans (Drawing A3).*[60]

Mr Paino was not advised of the background to the upgrade of the fire safety system. Nor was he given any documentary information to enable him to ascertain either the context or importance of the certification to both the renovations and the planned upgrade of the fire safety system in Unit 31. Presumably, there was sufficient expertise on the Project Control Group (Savona) with an understanding of the importance of the building surveyor's role. Indeed, certification by a major building surveyor was recently undertaken as part of the fire audit procedure.

The broad objective of the upgrade project was to '*bring the Fire Safety level of Kew Training Centre up to a reasonable level that will be acceptable to ... the certifying Building Surveyor*'.[61] Yet when significant renovations were about to be undertaken to a discrete unit – Unit 31, Building 37 – no information was provided to the new building surveyor about planned significant fire safety work. It is noted that work was also to be undertaken in Unit 31. This work was going to commence after the renovations.

Even Mr Lai, who was involved in the preparation of the audit on which the fire upgrade was based, was possibly not told of the renovations until they were almost complete. This was in spite of his clear recommendation that:

> *[u]pgrades of buildings should be referred to a professional fire protection engineer to ensure that there are no inadvertent consequences for fire safety of building fit out or furniture selection decisions.*[62]

On this issue the evidence discloses, at the least, a significant breakdown in communication over the issue of the 1995 renovations to Unit 31 or, at the worst, a failure to advise the consultants until late October. Indeed, Mr Vasan had clear knowledge of the fire risk to the residents, of the planned upgrade and much of the long history behind the process. None of this vital knowledge was imparted to Paino. In contrast, Mr Paino had no knowledge of KRS or its use. Mr Paino had come from Queensland in 1979. At first he worked and lived in Carlton, and then moved to Heidelberg working in Diamond Valley. He had not spent much time in the Kew/Hawthorn area and had not become aware of Kew Cottages (KRS).

Mr Stephen Kip, who had prepared a 'Certificate as to compliance with the provisions of the Building Regulations 1994' for the whole complex as recently as 1 March 1995, warned that

59 Exhibit 265.

60 Exhibit 258.63 – Mr Paino's statement.

61 Exhibit 162, para. 2.2 (emphasis added).

62 Exhibit 143 – ULA Report.

'3. Any change of building use or occupation outside of those specified in the audit will require further analysis by a Registered Building Surveyor'.[63] Mr Kip, who worked for the Gardner Group, explained in his statement that the certificate was:

> *part of a fire risk assessment review and report undertaken by an independent team of consultants which included Gardner Group Pty Ltd.*[64]

He was of the opinion that:

> *[t]he certificate provides independent review and confirmation that the works mentioned within the report will, if satisfactorily completed, bring the fire safety in the building to a level which is equal to, or greater than, the minimum acceptable community standard intended by building legislation in Victoria. The certificate of compliance prepared by me provides confirmation of this and I still believe it to be true.*[65]

Annexure A to Mr Kip's statement 'Certificate Conditions and Exclusions' notes that '*4. All building fire safety systems (essential services), both existing and as required by the fire safety audit, are to be maintained as required by Part 11 of the Building Regulations 1994 i.e. ... Fire Detectors and alarm systems ... Smoke alarms'*.[66]

At the first meeting of the PCG (31 January 1995), the '*PCG requested ULA to seek confirmation from certifying Building Surveyor regarding the partial sprinkler proposal'*. A note to the minutes records *'(NB. Certifying Building Surveyor is Stephen Kip of the Gardner Group)'*.[67] At that meeting, Messrs Taylor and Vasan were marked as being present and representing Kew Cottages. Mr Savona was representing the Department of Health & Community Services. Clearly, both Taylor and Vasan were aware of Kip's involvement as a building surveyor to the project.

While the Gardner Group were involved specifically in the audit process, a question remains unanswered: why was advice not sought from Kip (the Gardner Group or ULA) as to the issue of certification of the renovations to Unit 31? It is noted that plans for these renovations must have been well in hand at the time that Kip certified the complex. The ProARK plan is dated 25/4/95. Kip and the Gardner Group were referred to in some PCG meetings. This unanswered question, along with the lack of formal involvement of ULA as fire auditor (and member of the PCG) until the renovations were almost complete, raises initial concerns about the management by KRS of the certification issue for Building 37, Unit 31. The comment may also be made, by example, that other vital information about fire risk and safety at KRS – the Dibben Report – was not distributed by CMB. It is in this broad context of established information breakdown that Mr Paino's involvement needs to be examined.

A level of information breakdown can be seen throughout the management of the fire safety systems and the upgrade at KRS. Other key examples are:

- failure to advise Jonkar of the various reports on fire safety – the Lumley, Dibben and ULA reports and the Fabric Survey. Each raise issues of maintenance;
- failure to advise Jonkar of the renovations (Jonkar only became aware on alarm calls); and
- a lack of communication between DHS and KRS advising that a maintenance audit was not being conducted by BSA.

63 Exhibit 258; see also Exhibit 285 – Gardner Group Report.

64 Exhibit 258; see also Exhibit 285 – Gardner Group Report.

65 Exhibit 258; see also Exhibit 285 – Gardner Group Report.

66 Exhibit 258.

67 Exhibit 224.

These are not the only examples of communication breakdown at KRS over this period.

There has been much criticism of Mr Paino for his role in this incident. For example, the Submissions for the State of Victoria (not the BSA) broadly suggest that he:

> *failed to make due and proper inquiries before certifying the plans. Due and proper inquiries were necessary to ensure that he applied the correct building classification pursuant to the Building Code of Australia. In his statement and evidence, he subsequently sought to conceal this failure by falsely claiming that Mr Vasan provided him inadequate and or misleading information.*[68]

The Parents' Association submitted:

> *392. It is apparent from Mr Paino's evidence that initially the job involved no more than bathroom alterations. Once the plans came to include a material change to bedroom layout, there is no doubt however that the job raised serious safety implications.*
>
> *393. Mr Paino should have appreciated the area of the building was greater than Unit 31, because the plan clearly showed the building extended to the west.*
>
> *394. He should have carefully identified the number of residents within the building, because that materially affected the standard of works required by him.*
>
> *395. He should have been alerted by the institutional nature of the use, to inquire carefully as to the nature of the residents. In particular commonsense suggests that he should have inquired more carefully as to who would live in the unit.*
>
> *396. Most importantly he should have inquired as to the extent of renovations in the previous three years. This was fundamental to compliance with the regulations. He did not ascertain whether the regulations required the whole of the building to be brought up to current standards or not.*
>
> *397. He did not specifically address the nature of exits although it was clear the renovations affected exit paths.*
>
> *398. ... [H]is certification was a direct cause of the manner in which the renovations were conducted and the circumstances in which they were deemed suitable for habitation.*[69]

The Parents' Association Submission for system changes tends to put Mr Paino's involvement into context:

> *400. Institutions such as KRS should be subject to a requirement for inspection of building works upon completion and certificates of occupancy.*
>
> *401. The Building Further Amendment Bill (1997) addresses this issue.*
>
> *402. The difficulties encountered with the casual retainer of Mr Paino echo elements of the case with respect to maintenance.*
>
> *403. Renovations must be subject to an integrated management approach.*
>
> *404. Renovations must not be implemented without full consideration of their fire risk implications in a situation of special risk involving buildings which form part of a broader complex.*[70]

The MFB's Submission is more circumspect when it says:

> *273. On the basis of Mr Paino's evidence, Mr Vasan's instructions were inadequate. Mr Paino also failed to question Mr Vasan and obtain adequate instructions. He gave the*

68 State of Victoria Submission, p. 247, para. 1.2.

69 Parents' Association Submission, p. 136. See also generally the Submissions of ULA '4.0 The Building Works to Unit 31', p. 33 et seq.

70 Parents' Association Submission, p. 137.

plans only cursory attendance and failed to appreciate the existence of Unit 30 as was suggested by the plans. His failure to examine Unit 30/31 when he was out on site and his failure to appreciate the magnitude of KRS points to an inadequate approach.

274. This demonstrates the importance of the point ... that it should not be left to Building Surveyors to determine the appropriate building classifications for residences for the intellectually disabled. Even if Mr Paino had received adequate instructions, he did not have the requisite experience or knowledge to make an informed decision about residences such as KRS.

275. Mr Vasan's inadequate approach must also be noted as must the subsequent failure of KRS to complete the renovations in accordance with the certified plans. The walls of Flat E were not constructed of one hour fire resistant material as noted by Mr Paino.[71]

In an attempt to answer the criticisms, Mr Paino's counsel put that:

[u]nfortunately, when Mr Paino undertook the certification process at KRS he was subject to the operations of a system which dealt with building approval for Government projects in a manner and form different from approval for private sector projects. It is a consistent theme running through the submissions already tendered that the tragedy at KRS is a sorry example of the failure of systems to achieve the ends for which they have been brought into existence. It is not the role of this submission to list those various histories of system failure, however, it is submitted, that in the context of such monumental systems failures it is entirely inappropriate to attempt to sheet home to an individual working within that system the responsibility for the outcome of the failure of those systems. It is clear from the evidence that there are apparent inadequacies in the certification system. The certification process can fairly be described as a much more informal process than the private sector building application process. While there is no evidence of comparison, the process involving KRS and Mr Paino seemed particularly informal. This is a concern developed in the Umow-Lai submission at paragraph 4.10. Of the points made in that submission one of considerable relevance to the broad context of Mr Paino's participation in this particular certification is "the absence of any real authority on the part of the building practitioner". It must be recalled that Mr Paino was of the understanding that he was being required to perform a certification for the Department of Human Services Victoria ("HSV").[72]

Further, counsel for Mr Paino stated that:

[t]he real issue for consideration of the Coroner in respect of the building certification process is that of a system failure within a much larger sclerotic system.[73]

Mr Paino made no inquiry of Vas an about previous building work at KRS. Also there is no indication of any discussion between the two men of KRS's history. Mr Paino's counsel submits that he:

had no prior knowledge of the repetitive expressions of concern, enquiries into and reports on fire security matters which had long preceded his engagement. It is axiomatic that the HSV was aware of this background and, to a large extent, it can be assumed that Mr Vasan (who had commenced at KRS in or about July 1990) was too. In fact, from the MFB Chronology it is indicated that Mr Vasan had considerable awareness of the long and sorry history in this regard.[74]

71 MFB Submission, p. 157.

72 Paino's Submission, p. 2, para. 5.

73 Paino's Submission, p. 33, para. 58.

74 Paino's Submission, p. 3, para. 5.

It is reasonable to draw the inference that Mr Paino was not told about KRS's fire upgrade.

It was argued by the State of Victoria that Mr Paino did not treat the certification process as if it were an application for a building permit. Under section 218(1) of the *Building Act* 1993, the Minister (of the relevant Department) must ensure that:

> *(a) there are lodged with the Council all plans, drawings and specifications for the work that would be required if the Crown or Public Authority had to obtain a building permit; and*
>
> *(b) Those plans, drawings and specifications are certified by a building surveyor registered under Part 11 to comply with the Building Regulations.*

Section 218(2) provides that '*[n]othing in sub-section (1) requires the Crown or a public authority to apply for or obtain a building permit or occupancy permit'*. Under this provision, it appears that the Minister must ensure that all relevant documentation is lodged with the Council that would be required as if the Crown had to obtain a building permit. Unfortunately, Mr Paino did not obtain all material in writing as for a 'permit application'. Apparently, he believed that he was only certifying. Support for this proposition is to be found in the following exchange:

> *Coroner: What would you do differently now?*
>
> *Answer: Well I would approach it – if I – I would approach it as a permit. I would get everything in writing as you do on an application form.*[75]

Counsel for the State of Victoria argued that this exchange indicates that Mr Paino did not understand the regulations. This is a matter of detail in the construction of the regulations as to whether he was being asked to 'obtain a building permit' or merely provide all material as if a permit were being applied for by the Department. He was being asked to do the latter.

Ultimately, the responsibility rests with the Minister. But Mr Paino did not address the issue of obtaining all the material as if it were a permit situation, and ideally he should have. However, in the circumstances, the comment of Paino's counsel is also telling:

> *It must be remembered that Mr Paino was dealing with a Government Department in the peculiar area of building certification. Perhaps it was naive of him to assume that he was being told the correct things and that he would not question and ask for documentary evidence or signatures on papers (which is more consistent with the process of building permit applications). That is because of the clear onus that s.218 casts on the Minister (and thereby that Department).*[76]

The type of detail required where a permit is being applied for under the Building Regulations 1994 (Regulation 2.1, Part 2) includes: sufficient information to show that the work would comply; and a statement of use or intended use of the buildings. This was not done.

It is noted that the important issue of the building surveyor and certification of the plans is not mentioned in Mr Vasan's statement. However, it is referred to in Taylor's statement:

> *Prior to the renovation of Flat E in Unit 31 the Ministry of Housing had constructed buildings from Fibron at KRS, such as Unit 3. In relation to the renovations at Unit 31 the builders were instructed on the tender documents to tender on Fibron rather than plasterboard as Fibron had been approved in the construction of previous units. Fibron is a lot stronger and more functional in residential units at KRS. In Unit 30 Fibron was specified in the plans. All renovations to building 37 were prepared by architects and*

75 Transcript, p. 6980; see pp. 1-2 of Paino's statement on certifying.

76 Paino's Submission, p. 18, para. 33.

draftsmen and I understood that the building surveyor certified such plans. The Gardner Group were engaged by ULA to evaluate the compliance of buildings at KRS with the Building Code.[77]

Mr Taylor gave evidence on the issue of 'Fibron' on 20 March 1997. The following exchange occurred between Messrs Osborn and Taylor:

Question: ... [A]t the foot of the next page, 13, there's reference to renovations to Flat E, and the use of the material Fibron. Did you consider whether you could have asked Umow Lai for a list of materials generally to be used in the renovation, that might reduce fire risk?

Answer: Yes, we did ask for that.

Question: You did ask for that?

Answer: Yes.

Question: When was that?

Answer: During the audit stage, and I think there was some – some comment in the final – in the audit report.

Question: Was this after the renovation of Flat E, or before?

Answer: This – this was after.[78]

On 18 March 1997, Mr Taylor gave evidence that he had asked Lai for *'less flammable materials'* and that they had discussed moving away from *'MFB board – or Fibron'* to a product called *'Bettaboard'*. Taylor also said that Villaboard is a *'non-flammable type material'*.[79] The Warrington Report states that, in Flat E, *'the wall linings were generally MDF except for the bathroom areas (cement sheet) and part of the corridor to Flat C (plaster), and the wall between Flats E and B'*.[80] The MFB stated that the internal linings in Building 37 *'varied considerably'* with a *'combination of Masonite sheet, masonry and Medium Density Fibre board'*.[81]

The Parents' Association suggests that *'the walls of bedroom 3 were constructed with Fibron, a particle board which effectively explodes upon reaching flashpoint'*.[82] The Villamanta Legal Service *'notes that Villaboard was used in the 1995 renovations'*.[83] However, on the available evidence, it is reasonable to conclude that Fibron was chosen for the 1993 renovations, but not for 1995.[84]

An examination of the evidence indicates conflict between Messrs Paino and Vasan in some areas. When inspecting the certified plan of Unit 31, there are indications that it extends to the east (towards an unmarked Unit 30). When Mr Paino was questioned on this issue, he stated:

Mr Osborn: If one looks at the plan, can you not see that the building extends to the east?

Answer: I did enquire about that, and I was told that – that was of no consequence.[85]

It was argued by counsel for the State of Victoria that this is an unlikely account. The contrary view was argued by counsel for Mr Paino that this does not appear to be Vasan's view. This line of questioning is used in support of the latter proposition:

77 Exhibit 159, pp. 13-14.

78 Transcript, pp. 5362-5363.

79 Transcript, pp. 5191-5192.

80 Exhibit 201, p. 4. MDF: Medium Density Fibre board.

81 MFB Report, pp. 28-29.

82 Parents' Association Submission, p. 71, para. 214.

83 Villamanta Legal Service, p. 59.

84 Mr Vasan's evidence in Transcript, pp. 6996-6997.

85 Transcript, p. 6916.

Mr Wicks: Is it reasonable to draw a conclusion from that statement that there is nothing of consequence going on next door?

Answer: Yes, (indistinct).[86]

However, an examination of the transcript does not fully support this contention. Vasan earlier answers:

Mr Wicks: That's similar to saying "There's nothing of consequence going on in Unit 30"; is that right?

Answer: No. I didn't say that. I said the renovation is only one end, that's all.[87]

From Mr Vasan's evidence, it is clear that Paino had sought some information on the state of the rest of the building which was next door. In view of the conflict between the two witnesses, it is difficult to determine the exact nature of that conversation.

Concern still remains that during the meeting between Messrs Vasan and Paino at the Administration Building, KRS, apparently the issue of the fire upgrade was not raised. In addition, Vasan had other opportunities to raise the issue: two telephone calls and when dropping off plans at Paino's residence. When it is appreciated that both Vasan and Taylor considered the work to be 'minor', the failure to mention this crucial fact is not surprising. However, it still does not excuse the failure to provide the information to Paino, nor can it be a full explanation for Paino not making further inquiries.

In another area of conflicting evidence, Mr Paino states that Vasan told him that the residents were in effect '*elderly people and related people'*.[88] This has significance as to how a building is classified. Vasan, on the other hand, denies this conversation, and states that he was not asked what type of people resided at KRS. If he was asked, he would have used the descriptive term '*intellectually disabled'*. Mr Paino considered that, in the event he understood Vasan to say '*intellectually disabled*', he would have conducted further investigation while the classification – 3 – may have remained the same.[89]

It is considered unlikely that Mr Vasan would use a term of art under the building law such as '*elderly and related'*. Equally, Paino would need some fundamental details to commence his work on the plans and certification. Thus it is considered likely that, at some stage, he did ask for some details of use, i.e. the nature of the residents. Support for this view comes, first, from his evidence. Secondly, it comes from his initial file note which says, '*if persons are unrelated'*, and thirdly from the facsimile sent to Vasan. The facsimile, which has not been found in Vasan's files, relates to certification of both the O'Shea Building and Unit 31. In part, it asks of O'Shea, '*2. If occupants of building are unrelated provide 1 hour fire doors to bedrooms'*. For Unit 31 there is no such query: the fire doors and walls are specified. At this stage the lack of a query may lend support to the fact that Paino thought he knew the nature of the residents in that building.

It was suggested by Mr Paino that he was '*quite clear that he (Vasan) said elderly, related'*,[90] and was '*absolutely positive'* that he asked what type of people lived in the buildings.[91] Paino said there were language problems:

86 Transcript, p. 7007.

87 Transcript, p. 7007.

88 Exhibit 258.63 – Mr Paino's statement.

89 Transcript, p. 6913.

90 Transcript, p. 6913.

91 Transcript, p. 6975.

I had difficulty dealing with Srini and understanding him'... 'I believe I asked him, or I was given information I required, and on that basis I had no doubt that I was doing a correct certification.[92]

Mr Vasan stated that '*Piano [sic] never mentioned any difficulty understanding me or that there were any difficulties at all'*.[93] Having heard Mr Vasan during evidence and reviewed the transcript, it is considered that Paino's account of having a difficulty with understanding Vasan is feasible. Thus there was a real possibility of a communication breakdown between the two men.

There is another area of evidence which is difficult to resolve. When describing the number of contacts Paino had with Vasan, he states that:

there were perhaps two other telephone conversations. One conversation was in response to the fax I sent dated 8 May. I seem to recall another conversation. In that other conversation I asked Mr Vasan about the number of people occupying the building. I can't remember his exact response but was satisfied that it was less than 20 people. I noted also that there were 10 rooms in the Lower Drive building and assumed that the maximum number of people would be 2 per bedroom.[94]

Presumably, there was no reason for Vasan to specify 20 people when he knew there were 25 to 26 in residence (for Unit 31 only). Yet, about two years after the event, Paino frankly puts his recollection. Effectively, he reconstructs his reasoning. It is noted that Paino was apparently unaware of his involvement in the inquest until shortly before he made the statement. The statement is dated 15 April 1997. In evidence, in the last days of the inquest, Paino did not demur from the fact that he made calculations as to resident numbers based on the number of rooms. As to the conversation with Vasan, he stated:

I am not positive and I can't answer that I remember exactly what Mr Vasan said to me, but I was satisfied on that point there were no more than 20 people in the building.[95]

Further, he stated that '*I'm sure Vasan satisfied me that there were not more than 20 people'*.[96] Later, he said that *'I believe I did ask Mr Vasan how many people lived in the unit'*.[97]

The ULA Submission suggests that the causes of the failure of the building certification system in May 1995 to address the building problems associated with fire safety are:

- *the building practitioner was not briefed and did not make enquiries to discover the correct class of the building (it was class 9(a) not class 3) and failed to note that a change of class resulted in an immediate requirement to bring the whole building up to standard.*
- *the fire safety measures endorsed on the plan were inadequate for the intensive residential use in fact made of unit 31 by 32 plus residents not a maximum residential occupation of 20 persons as was the basis of the fire safety standards imposed by the building practitioner*
- *a total misunderstanding occurred as to the nature of the occupants ("elderly and related persons")*

92 Transcript, p. 6921.

93 Transcript, p. 6993.

94 Exhibit 258.26 – Mr Paino's statement.

95 Transcript, p. 6913.

96 Transcript, p. 6913.

97 Transcript, p. 6970.

- *no information was provided and no enquiries were made by the building practitioner as to other alterations to the building within the previous period of 3 years*
- *the building practitioner did not sight the municipal building file and so did not know the class of the building nor the building's past use or history*
- *the building practitioner did not see or inspect the condition of the existing building at any time before certification*
- *no inspection of the works occurred during or after the construction period from May-November 1995 in contravention of the Ministerial guidelines*
- *in the absence of inspection, the unsafe state of the building was not identified*
- *fire hazardous materials were employed during the refurbishment contrary to the "Guidelines for Building Refurbishment" being Appendix X of the ULA – SSL report delivered only 9 months earlier [Note: the evidence is that this did not in fact occur.]*
- *no fire safety plan for unit 31 was conceived or implemented despite the fact that management was in possession of the ULA designs for the fire safety upgrade of this unit*
- *the existence of the ULA fire safety design for the upgrade of unit 31 was not made known to the certifying building practitioner.*[98]

In the end, ascertaining the sequence of events between witnesses two years after a limited and once only professional dealing is difficult, if not impossible. Likely communication difficulties make the task far more difficult. A lack of adequate documentation by way of a briefing paper to Paino by KRS is an added factor. However, it is possible to come to some fundamental conclusions on the issues.

There was no examination of Mr Paino's level of experience, qualifications or understanding of the issues facing KRS by Vasan. The selection process left a lot to be desired, considering that this was such an important role. It was left to a maintenance engineer to do the hiring and managing when required expertise was within the PCG. Insufficient information was given to Paino to enable him to carry out his task properly. Sufficient detailed information was at hand at KRS to assist Paino in his role. Unfortunately, it was not given to him.

Against this background, it is clear that Mr Paino should have been more persistent in his inquiries to ascertain the information he required. Mr Paino first met Vasan at KRS in the Administration area. He did not go to Building 37. Apparently, Vasan did not take Paino to Building 37 which was nearby.

A developed system for dealing with building controls, as was suggested in Kew's own 1994 Fabric Survey and by the tenor of the 1994 Ministerial Guidelines, would have gone a long way to alleviate problems with communication breakdown. A complete briefing would have been provided to Paino on the already identified fire safety issues. Unfortunately, no such system was in place.

However, putting the building surveyor's role into context again is the evidence of Mr Vasan:

> *Question: You were conscious, were you, as the works were proceeding, that the building when completed, in accordance with those works, would not meet acceptable fire safety standards?*
>
> *Answer: Yes, at that time, but we know we are going to do the upgrade within months, so it should have been done at that time.*
>
> *Question: So although there was a risk that the building would be completed and used, you were happy as it were to accept that risk?*

98 ULA Report, pp. 36-37, para. 4.12.

Mr Redlich: I object to that, Your Worship. I trust my friend appreciates that the residents were not occupying the building during the period of the renovations and that prior to –

Coroner: But presumably they were to occupy the building after the renovations?

Mr Redlich: Correct; … .[99]

In summary, the ULA Report makes a telling point that '*[w]hilst the building approval system may not be a failsafe mechanism, it is intended to and should provide a high level of public assurance and security that approved building work will be fit for public use and occupation*'.[100] In this case it did not operate to achieve this end.

5.2.3 THE BUILDING SURVEYOR AND KRS MANAGEMENT

ULA submits that the failures during the renovation process for Unit 31:

have a strong temporal and causal relationship to the severity of the fire on 8 April 1996 in that:

- *the building works were completed only 6 months before the fire*
- *the building works left unit 31 in the configuration and condition which it was in at the time of the fire (i.e. combustible materials, roof space, lack of detectors, fire walls and sprinklers)*
- *fundamental fire safety issues were not identified during the approval process and no professional fire engineer was engaged*
- *the fundamental object of the approval system viz. to ensure that the building was left in a safe condition was not achieved.*[101]

The failure by KRS management to advise the building surveyor of the upcoming fire upgrade leads to concern. When a failure to advise the fire engineering consultant of the renovations to Unit 31 is added, the problem compounds. The true picture of the role of the building surveyor can be seen in Mr Vasan's evidence:

Question: You were conscious, were you, as the works were proceeding, that the building when completed, in accordance with those works, would not meet acceptable fire safety standards?

Answer: Yes, at that time, but we know we are going to do the upgrade within months, so it should have been done at that time.[102]

It is accepted that KRS management took the risk associated with completing the renovations prior to the upgrade.

99 Transcript, pp. 6016-6017.

100 ULA Report, p. 36, para. 4.11.

101 ULA Submission, pp. 37-38, para. 4.13.

102 Transcript. pp. 6016-6017.

PART 6 ROLES OF CONSULTANTS, CONTRACTORS AND MANAGEMENT IN CONTEXT

This Part draws together many of the issues associated with the diverse areas on which advice was received from fire safety consultants, the role of a building surveyor and work undertaken by independent contractors on the fire alarm system at KRS. Throughout the Findings, the roles and interaction of these various agencies is dealt with in more detail.

In this context the role of management is also considered. The concluded view is that management bears the principal responsibility – by failing to follow advice and in not managing the risk. While some problems are identified in the detail of the advice by the consultants, such as ULA, they are only factors in the wider systemic management problems. The failure of the responsibility of the maintenance contractor – Jonkar – to follow Australian Standards is examined. The role of the building surveyor – Ashlar – is also considered. It is considered, in relation to Wormald, that it is unlikely it played any part.

Essentially, this Part is a summary of the many issues that beset management, the contractors and the consultants during the period leading to the upgrade of the fire protection system and the fire. Thus it does not seek to cover all issues involved or to deal with them in depth.

6.1 INTRODUCTION

In its Submission, the State of Victoria put into context one of the principal reasons behind examination of the role of consultants and independent contractors in the events. The State suggests that '*the primary object of the inquest is to ensure as far as is possible the tragedy at KRS does not re-occur in our community'*. Thus it is critical to identify:

> *such acts or omissions of any persons that led to the fire protection system being or operating inadequately at the time of the fire. The State of Victoria, by focusing on such questions, was not doing so in the understanding that it would necessarily be relieved of any (legal liability) duty of care which it held, but did so because the State of Victoria and also the private sector will continue to be dependent on experts in advising upon, designing, implementing and maintaining fire protection systems and achieving the maximum level of fire safety at any given time.*[1]

It is suggested in the Submission that the checks and balances of independent consultants and contractors '*fail the State of Victoria'*.[2] A critical examination of the role played by the consultants, while identifying some real shortcomings, reveals, however, that the consultants, in delivering advice, did not fail. Principally, the failure was with the State in not heeding and managing the totality of the advice. On the issue of the role played by the contractors, it can be said that at least one contractor, Jonkar, did not maintain the fire alarm system in accordance with Australian Standards, and it did not properly advise DHS of the deficiencies in the system. To that extent, at the very least, it failed the State of Victoria and the residents at KRS. For Jonkar contribution to the deaths is a different issue.

1 State of Victoria Submissions in Reply, p. 30, para. 3.6.

2 State of Victoria Submissions in Reply, p. 30 et seq. (section 3E).

Another contractor – the building surveyor Ashlar – did not make the appropriate inquiries of KRS and the council as to the relevant fire safety issues. To that extent it failed KRS. However, what must be borne in mind is that Ashlar was not given any information about the imminent fire upgrade at KRS. It was kept in the dark. In the end this also occurred to Umow Lai & Associates Pty Ltd (ULA) because it too was not advised of a critical issue – the impending renovation works to Unit 31. Even those responsible for managing and caring for the clients at KRS did not receive adequate information internally on fire safety issues from the services area at the complex.

The detailed examination of the respective roles of both consultants and contractors has identified a number of issues that will need to be addressed in the future. Indeed, there are many lessons for contractors and fire safety and building consultants. Management too will need to view how its interaction with consultants and contractors can adversely affect fire safety issues.

The primary object of the inquest is to investigate and to deliver findings in the particular areas of identity, cause and contribution. However, the parties have taken the lead and developed the direction of this inquest towards prevention and, in that regard, have identified several shortcomings in the present fire safety system in operation in some areas of our community. In particular, the State of Victoria has developed a model approach for the Department of Human Services and its areas of responsibility.

ULA suggests other reasons for the failures as being, in part:

> *the failure by the time of the fire to implement in any or any co-ordinated or timely way the Dibben, Lumley, MFB, and ULA – SSL reports recommending the urgent completion of fire safety upgrade works despite the elapse of 21 months in the case of the ULA – SSL report and several years in the case of the other reports.*[3]

This view is assessed in the overall framework of the systems failure.

Both historically and practically, the State, through its various agencies, was always the party best equipped to source, scrutinise and distribute acquired learning about the adequacy of the KRS fire safety system. It also had a monopoly over final decision-making as to how such advice was to be implemented and as to what systems it adopted for capital expenditure assessment and maintenance audit. As such it was the only party finally in the driver's seat.

6.2 THE CONSULTANTS AND MANAGEMENT

6.2.1 ULA

The 1994 ULA Report provided the impetus for the installation of an upgraded addressable alarm system combined with a sprinkler system. At the time of the fire that installation was well on the way to completion. However, ULA did not complete a 'full audit' but only drew the attention of KRS/DHS to a number of deficiencies and risks with the fire safety system at KRS. Nonetheless, it is noted that ULA also recommended re-instatement of the Fire Safety Committee, which was not done. Improvements in fire drills and evacuation procedures were recommended. Again, there was no action. Generally, apart from the addressable/sprinkler system, other recommendations made by ULA were not followed.

ULA did acknowledge some shortcomings in its report. In summary these were:

- the maintenance of the detector system or circuitry;

3 ULA Submission, p. 39, para. 5.1.1.

- the absence of circuit and detector plans;
- the locked doors; and
- fire-lighting risk.

Nevertheless, as stated earlier in the Findings:

> ULA admitted that it failed to draw sufficient attention to some specific management issues. Whether or not the audit was to be a 'full audit' is problematical. The parties to the audit may well have had a different understanding of what was required. Mr Lai's view was that the *'emphasis'* was on '*the urgent replacement'* of the existing system.[4] The view at KRS as expressed by Taylor, the Services and Facilities Manager, was for '*a comprehensive fire prevention audit to provide the basis upon which the fire safety system would be improved'*. Mr Vasan, the Maintenance Manager, expected a full fire safety audit on everything.[5]
>
> The end result is that the admitted problem for the ULA audit was with some of the detail, rather than the broad conceptual document. Certainly, a detailed building by building audit would have *'more fully'* identified deficiencies in the system. However, on balance, KRS/DHS already had a long and sufficient corporate knowledge of reports and failings. Each of those reports detailed areas that needed to be addressed. Many of those deficiencies and recommendations had not been systematically addressed long before the time ULA delivered its audit. The failure to address systematically the earlier recommendations meant that problem areas remained hidden. Even after ULA's audit, those problems remained and many issues that were pointed out by ULA were not resolved at the date of the fire.

Along with the compilation of the ULA Report, KRS also sought advice on interim solutions pending the upgrade. Ultimately, ULA advised that there were no suitable interim solutions. A number of alternatives were considered, and SSL was also involved in giving advice. There was no written project brief for the interim solutions, and the scope of the arrangements had to be drawn from the original meetings selecting the consultant. Despite some assertions to the contrary, it is reasonable to conclude that there were limits. Any interim solution had to be low cost and able to be integrated into the final solution. ULA expected the project to proceed to completion within its suggested time line of about 28 weeks (seven months). Instead it was still not complete some 21 months later.

Earlier, in 1993, Messrs Savona, Taylor and Vasan had worked for most of the year on interim hardware solutions. There was considerable knowledge at management level as to what was available and the cost. Unfortunately, the suggested systems were not approved which resulted in a decision not to go ahead.

ULA was on the Project Control Group (PCG) for the upgrade. However, in spite of a recommendation for a fire engineer's assessment for renovations, ULA was not informed of the 1995 renovations to Unit 31 until the residents were about to be moved back into residence. In addition, ULA was regularly on site, so the obtaining of advice would not have been difficult. These renovations significantly changed the way in which the unit operated and created additional problems for supervision and evacuation at night with low staff numbers. There was an opportunity for KRS to manage the fire safety issues and the renovations. What it chose to do is explained in evidence by Mr Vasan:

4 Transcript, p. 3562.

5 See Exhibit 232, p. 7; Transcript, p. 5828.

Question: You were conscious, were you, as the works were proceeding, that the building when completed, in accordance with those works, would not meet acceptable fire safety standards?

Answer: Yes, at that time, but we know we are going to do the upgrade within months, so it should have been done at that time.[6]

Consistent with the failure to advise ULA, Mr Vasan did not inform Ashlar about the fire safety upgrade when seeking the building surveyor's certification for the renovations.

6.2.2 SSL

SSL did not have a direct relationship with KRS, DHS or the State of Victoria. The real position both as to how SSL presented and how it was engaged is that SSL was a subcontractor to ULA. Although SSL's 'audit' of Building 37 is lacking in detail, it assisted in providing the information to enable the ULA Report to recommend a new system and sprinklers.

The Fabric Survey was being undertaken at the same time as the SSL part of the ULA 'audit' was being prepared. Along with other fabric-related issues, the Fabric Survey detailed, on a 'building by building' basis, the fire safety systems. It is puzzling that KRS/DHS would seek to duplicate some of the work of a fire audit for the same premises at the same time.

It is clear that, had management required the detailed 'audit' to be prepared that is now sought to be relied upon after the fire, the cost of preparation would have been considerable. Mr Savona's evidence appears to suggest that DHS (CMB) was satisfied with the level of audit eventually obtained by ULA.

6.3 THE CONTRACTORS AND MANAGEMENT

6.3.1 JONKAR

Jonkar's involvement at KRS was well short of satisfactory. Jonkar did not comply with a significant number of Australian Standards, and it was obliged to do so under its contract with BSA. Over the years, while performing regular maintenance on the fire protection system at KRS, it had the opportunity to assist in improving the safety of the system by advising of identified deficiencies. It did not do so.

Over the years, the State of Victoria was entitled to rely on Jonkar to advise regularly of deficiencies in the fire safety system that it was maintaining. Jonkar was in the best position of all to advise on the problems. As is put by the Parents' Association, '*[n]o one at KRS or in Human Services or BSA was capable of appreciating what was going on unless Jonkar had told them*'.[7]

Consistently, when problems developed with smoke detectors as a result of building work, Jonkar would 'temporarily' replace the detectors with thermals (Mr Taylor at KRS was aware that smoke detectors were being changed with thermals). Jonkar's evidence was that, on return after the renovations were complete, it would re-instate the smoke detectors. There were no records kept of such work. The court has no confidence that this in fact occurred in all cases. Because of the lack of smoke detectors in the bedrooms of Flat B, there is little confidence that re-instatement occurred in Building 37.

Although it is considered likely that there were no smoke detectors in the bedrooms of Flat E on the night of the fire, there are some areas of doubt. The conclusion by the Warrington Report as to the probability of failure of smoke detectors raises some of those doubts:

6 Transcript, pp. 6016-6017.

7 Parents' Association Reply, p. 2, para. B4.

Since a number of non-compliances with the design code were identified in Units 30 and 31, it is considered that the system would have a below average reliability and therefore there was a significant probability for failure of the detection system in place at the time of the fire.[8]

Significantly, Jonkar's counsel points to the fact that '*the State of Victoria knew that its fire detection system did not even begin to comply with the relevant Australian Standards. Nonetheless, it purported to require its contractor to comply with the Australian Standards*'.[9] While this submission must also be viewed in light of the fact that there were a number of specific areas in which Jonkar would have been in a position to alert DHS/KRS, it still makes a telling point. Reports such as those prepared by the Fire Brigade, Lumley, Dibben and ULA put the State on notice of the general inadequacies in the fire safety system. Jonkar was in the best position to advise on specifics. Many of the specific deficiencies would have been able to be rectified within KRS's maintenance budget.

The State of Victoria lists the following areas in which Jonkar breached its duties (by failing to follow the Australian Standards):

(1) Incorrectly placing detectors and/or failing to rectify the incorrect placement of detectors;

(2) Failing to perform a thorough visual inspection of detectors for factors that could adversely affect their functioning;

(3) Installing and/or failing to rectify the installation of an excessive number of detectors on Circuit 39;

(4) Failing to ascertain the status and verify the integrity of wiring in Unit 30/31 and failing to inform BSA or KRS of any potential deficiencies as a result of faulty or aged wiring.

(5) Keeping poor records and inadequate plans,

(6) Insufficient training, instruction and supervision of Jonkar Staff.[10]

Jonkar submits that '*none of the comprehensive reports into the state of the fire detection system at KRS criticized Jonkar'*[11] about the condition of the fire protection system. It argues that the failure to raise the issue of strict compliance with Australian Standards meant that compliance was not required – it was an impossibility. The evidence is that the State of Victoria, DHS, BSA and KRS did not know. Compliance was required.

In addition, Jonkar argues that it performed the contract to the 'satisfaction of the superintendent' – Mr Stewart. It maintains that '*Mr Stewart was clearly satisfied with the performance of Jonkar'*.[12] This argument is not persuasive because Mr Stewart was not conducting a 'technical audit.' Equally, any supporting comments of Vasan, the Fire Brigade or Dibben are not of assistance because the work of Jonkar was not examined in any detail prior to the supportive remarks. Unfortunately, an investigation was not undertaken, an investigation which would have discovered numerous breaches of Australian Standards and a practice of regularly swapping smoke detectors with thermals rather than fixing the problem causing the smokes to go into alarm.

Accordingly, any endorsement of Jonkar's maintenance role must have been made on a fairly superficial examination of what was actually occurring at KRS.

8 Exhibit 201, p. 17.

9 Jonkar's Reply, p. 14, para. 3.6.

10 State of Victoria Submission, p. 230, para. 1.215.

11 Jonkar's Reply, p. 14, para. 3.7.

12 Jonkar's Reply, pp. 14-15, para. 3.8.

Despite Jonkar's failures over the years, there are a considerable number of mitigating factors that fall squarely on management's shoulders. These are:

- The fire detection system was in a state of disrepair when Jonkar was awarded the contract in 1991.
- There was a failure to consult Jonkar about the installation and placement in 1993 of 235 FFE detectors.
- Jonkar was not advised when renovations were to be carried out.
- Jonkar was not a member of the fire safety committee and was not kept appraised of fire safety issues.
- Jonkar was not advised that any resident had fire-lighting tendencies.
- Jonkar was not involved:

  [i]n the up-grade of the fire detection system. With respect to building 37, Jonkar was not requested to attend in January 1996 to ensure that the detection system it was responsible for maintaining was not being compromised by the work of Wormalds. Neither was Jonkar informed that building 37 was left by Wormalds for several months with the new system in a state of partial completeness. The existing system was to continue to provide protection for the residents of building 37, but more than a dozen different workers had carried out extensive works sometimes centimetres from the existing detection equipment. Jonkar was not informed. It was not requested to attend to ensure that building 37 was covered by the existing fire detection system.[13]

  [While it is not considered likely that Wormald interfered with the system, on the issue of risk management Jonkar should have been involved.]

- Jonkar was not given copies of the various reports on the fire safety system at KRS.

On balance, while Jonkar's performance warrants critical comment in a number of areas, that performance was essentially a symptom of overall systemic failure rather than the real genesis or exclusive cause of failure.

6.3.2 WORMALD

A number of theories have been put forward suggesting that Wormald or its subcontractors were involved in compromising the then existing fire safety system. Wormald and its contractors were essentially the last contractors to work on the system (although there was some work on airconditioning and removal of installation after Wormald left the building). Thus, it has been suggested by Jonkar and the State of Victoria that Wormald's work must have caused the system to fail.

Wormald was responsible for installing the new system and worked beside the existing fire system. Its work ceased on 17 January when asbestos was discovered in the roof space. The theories put forward to explain Wormald's involvement in the sytem failure ranged from cutting into the system, by-pass, reverse polarity to removal of the 'end of line resistor'. The theories were not supported in any detail by the experts in their agreed statement made towards the end of the inquest. Accordingly, none of them is considered as being likely. In addition, it is not considered that the theories are supported by a number of the witnesses.

Although the theories involving Wormald have been rejected as unlikely, the conclusion by the Warrington Report as to the probability of failure of smoke detectors raises concern about system reliability:

13 Jonkar's Reply, pp. 15-16, para. 3.10(e).

Since a number of non-compliances with the design code were identified in Units 30 and 31, it is considered that the system would have a below average reliability and therefore there was a significant probability for failure of the detection system in place at the time of the fire.[14]

These issues are not Wormald's responsibility.

The State of Victoria has also suggested that Wormald was responsible for effectively 'auditing' the wiring before the system was installed. DHS decided to re-use the existing wiring – as long as it was functional. This option saved about $50 000 on the contract. Wormald explained that:

[t]he decision to re-use the existing wiring meant that those sections of the contract dealing with the standards applicable to the installation of new wiring did not apply. Where any new wiring had to be done as a result of the functional inadequacy of the old wiring, that would be charged to KRS as an additional expense.[15]

The check on the wiring was made on the day of changeover when the system was connected. Evidence was given that:

because of the sophisticated functions of the new FIP and the analogue addressable detectors, it was far more efficient to check the functional integrity of the existing wiring on the day of changeover when the detectors were already connected to the old wiring. Any defects could then be remedied as part of the changeover process.[16]

It was suggested by the State of Victoria that Wormald was to undertake a detailed check of the wiring before work commenced. On the practicality of undertaking a detailed assessment, Wormald submitted that:

[t]o have done a detailed assessment of wiring for which there were no plans, and which was in conduit and buried under insulation, would have added a layer of cost and difficulty that would have meant that it would have been little cheaper than installing new wiring.[17]

It is clear that by taking the option to use the existing wiring DHS was attempting to minimise costs. Although re-wiring was the preferable long-term option, Wormald points to the fact that it was a decision for DHS to make.

On 25 January 1996, Wormald wrote to Mr Mitchell stating that '*currently all existing fire alarms in Unit 30/31 are still operational and have not altered in any form. All new equipment is inactive*'.[18] The State of Victoria effectively says that Wormald was not in a position to make this statement without checking every detector. Wormald also suggests that it '*was entitled to assume that the existing fire detection system in Unit 30/31 was functional and being properly maintained by Jonkar, the existing maintenance contractor. As the Coroner discerned, (T 5126) Wormald's letter dated 25 January 1996 meant and was understood to have meant that the existing detection system had not been altered*'.[19] Wormald points to the practical difficulties of testing every detector on the system in its area of daily work:

The assertion would mean that Wormald would have had to test every detector on every building after every day of work. There would have been a similar duty on the air-

14 Exhibit 201, p. 17.

15 Wormald Submission, pp. 8-9, para. 1.22.

16 Wormald Submission, p. 10, para. 1.25.

17 Wormald Submission, p. 9, para. 1.23.

18 Quoted in the State of Victoria Submission, p. 204, para. 1.132.

19 Wormald Reply, p. 17, para. 5.12.

conditioning and insulation removalists who worked on the building subsequent to Wormald's departure. There was no such duty.[20]

The Public Advocate suggested that Wormald should have notified DHS that there were incorrectly placed thermal detectors in Flat E. It answers this allegation by saying that:

[m]ost of the bedrooms in Unit 30/31 had thermal detectors, as did most of the bedrooms at KRS. Wormald was entitled to assume that KRS knew this. There had been a fire safety audit and lack of smoke detectors was one of the reasons for the upgrade. Even if Wormald had known there were no smoke detectors in Flat E, to have told KRS that any particular Flat at KRS did not have smoke detectors in it would have been to state the obvious.[21]

In a number of minutes of Site Meetings, Wormald warned that '*they cannot guarantee the integrity of the existing wiring or supply as wired drawings. They will test each existing circuit for alarm and fault condition prior to disconnection*'.[22] This statement clearly indicates Wormald's level of responsibility. It was reasonable that the check on the wiring was made on the day of changeover when the system was connected. Practically, as Wormald submits, it '*believed and was entitled to believe that KRS knew of the general deficiencies of the system at KRS, that it had been the subject of an audit, and that these deficiencies were the reason for the upgrade*'.[23]

It is not accepted that there was any agreement to check the wiring at any stage other than when the new system was connected. That was to be done with the assistance of the new addressable system. In the circumstances, it was a reasonable work method.

Accordingly, the submissions to the effect that Wormald was responsible for the systems failure are not made out.

6.3.3 ASHLAR

Ashlar, the building surveying company, was engaged by Mr Vasan to provide the appropriate building certificate for the 1995 renovations to Unit 31. Apparently, Ashlar was selected because its principal, Mr Paino, lived in the same street as Vasan.

During the renovations, the residents were relocated for about six months and the unit was vacant. The works were undertaken between May and November 1995, and included:

- conversion of three bedrooms into a kitchen/living area, and bathroom;
- renovation of two bathrooms;
- removal of a wall to create a kitchen/living area;
- relocation of bedroom door 9 from the northern to southern wall; and
- creation of bedrooms in Flats C and D.[24]

During the renovations, some detectors were replaced by Jonkar – in the kitchen/bathroom area. However, a fire safety plan was not prepared.[25] The building remained with the reported 'inadequate' fire safety system until the fire.[26]

20 Wormald Reply, p. 17, para. 5.11.

21 Wormald Reply, p. 23, para. 1.8.

22 Wormald Submission, p. 9, para. 1.24.

23 Wormald Reply, p. 16, para. 5.7.

24 Exhibit 176 – Mr Vasan's statement, pp. 7-8; Transcript, pp. 6011-6012.

25 Transcript, p. 6022.

26 See the Lumley, Dibben and ULA reports and the Fabric Survey.

When Messrs Paino and Vasan met at KRS's Administration Block, Unit 31 was not inspected. After that first meeting, questions were answered over the telephone, and amended plans were collected from Paino's home by Vasan. Mr Paino, who was not aware of KRS's history, believed that the residents were 'elderly and related' rather than intellectually disabled. There was an accepted breakdown of communication between the two men – which resulted in Paino having an incorrect view of KRS's residents. Significantly, Vasan did not tell Paino about the imminent fire upgrade. Ashlar did not inspect the completed works.

Briefly, ULA suggests that the causes of the failure of the building certification system in May 1995 to address the building problems associated with fire safety were:

- *the building practitioner was not briefed and did not make enquiries to discover the correct class of the building (it was class 9(a) not class 3) and failed to note that a change of class resulted in an immediate requirement to bring the whole building up to standard.*
- *the fire safety measures endorsed on the plan were inadequate for the intensive residential use in fact made of unit 31 by 32 plus residents not a maximum residential occupation of 20 persons as was the basis of the fire safety standards imposed by the building practitioner*
- *a total misunderstanding occurred as to the nature of the occupants ("elderly and related persons")*
- *no information was provided and no enquiries were made by the building practitioner as to other alterations to the building within the previous period of 3 years*
- *the building practitioner did not sight the municipal building file and so did not know the class of the building nor the building's past use or history*
- *the building practitioner did not see or inspect the condition of the existing building at any time before certification*
- *no inspection of the works occurred during or after the construction period from May-November 1995 in contravention of the Ministerial guidelines*
- *in the absence of inspection, the unsafe state of the building was not identified …*
- *no fire safety plan for unit 31 was conceived or implemented despite the fact that management was in possession of the ULA designs for the fire safety upgrade of this unit*
- *the existence of the ULA fire safety design for the upgrade of unit 31 was not made known to the certifying building practitioner.*[27]

As a building surveyor, Ashlar was responsible for ensuring that proposed renovations to Unit 31 complied with the building regulations. However, there are difficulties in the classification of buildings housing the intellectually disabled. For example, Unit 31 has been classified by experts as either Class '3' or '9(a)'. Some consequences for fire safety depend on the classification. The Warrington Report comments that '*there have been conflicting views expressed as to the classification of the building*' and '*... [t]he criteria nominated by the BCA does not address issues specific to the type of occupancy and facilities such as Kew Cottages do not sit easily within either the Class 3 or Class 9a categories*'.[28] In a more strongly worded conclusion, Warrington is of the view:

> *11.2 Current building regulations and the technical provisions within the Building Code of Australia are inadequate for facilities such as Kew Residential Services. The adoption of the BCA 1996 and the proposed amendments to the Victorian Building Regulations will address some of the major limitations.*[29]

27 ULA Report, pp. 36-37, para. 4.12.

28 Exhibit 201, p. 27.

29 Exhibit 201, p. 30.

Ashlar classified Unit 31 as 'Class 3' and required fire resistant wall linings. The differences between '3' and '9(a)' for buildings at KRS are summarised by Warrington as including: compartmentation; fire hose reels; smoke and fire detection system; alarm system/EWIS system; early fire hazard indices for linings; and egress provisions. But, the large number of variations *'did not contribute to the fatalities which occurred on the 8 April 1996. However under other circumstances they could critically have affected the outcomes'*.[30] Warrington notes that the '9A' class does not specifically retrospectively apply to KRS as *'they form the most obvious guide to achieving a reasonable level of safety for building owners/operators to adopt'*.

Ashlar was kept effectively 'in the dark'. Its responsibility must be balanced accordingly. Mr Vasan's evidence shows an acceptance of the risk at some management levels at KRS – both Vasan and Taylor were aware of the renovations. Whether more detailed work by the building surveyor would have effectively operated to change this approach is a moot point:

> *Question: You were conscious, were you, as the works were proceeding, that the building when completed, in accordance with those works, would not meet acceptable fire safety standards?*
>
> *Answer: Yes, at that time, but we know we are going to do the upgrade within months, so it should have been done at that time.*[31]

In considering Ashlar's role, it must also be borne in mind that the fire consultant – ULA – was not advised of the renovation work to Unit 31 until it was almost complete. It had recommended a fire engineer's report be obtained prior to renovation works. That recommendation was ignored. ULA was on the PCG, and it still did not receive the correct information as to what was happening at KRS.

Again, the shortcomings of Ashlar's involvement can be classified as symptomatic and indicative of systems inadequacies rather than as fundamentally causative.

6.4 CONCLUSION: MANAGEMENT RESPONSIBILITY

In the context of extensive systemic failures, the involvement of the consultants and contractors such as ULA (or SSL), Ashlar and Jonkar must be seen as factors in the wider picture leading to the tragic fire. Ultimately, management, whether it be at KRS, CMB level (or in the broader context by DHS) must share the overall responsibility for the incident. There are so many failures of communication at management level that it is difficult to discern precisely what information was given to the various consultants about the system. Certainly, one consultant was told very little; others were not informed about crucial issues at critical times. Advice was either not taken or ignored. Risks were taken without advice.

These failures of communication can be demonstrated by a failure to communicate in key areas, a failure to follow advice and, finally, a failure to manage the risk.

In summary, examples of the failure to communicate in key areas are:

- CMB not seeking the further involvement of Winn/Newton on presentation of the draft Dibben Report to CMB;
- CMB failing to advise KRS of the details of the 1993 Dibben Report;

30 Exhibit 201, p. 30.

31 Transcript, pp. 6016-6017.

- CMB not advising (through the PCG) either KRS, ULA or both of additional interim and/or management issues in the Dibben Report. Senior management from CMB on the PCG had the detailed knowledge;
- Not examining the maintenance audit issue (sufficient recommendations were contained in the Dibben/ULA reports);
- Not communicating adequately on the issue of maintenance audit between KRS, DHS and BSA;
- DHS not adequately communicating to KRS management and staff on the fire-lighting risk, which led to a failure by management to advise staff or a failure by staff to advise management on the fire-lighting risk;
- KRS management not advising ULA (or the PCG) about the renovations to Unit 31;
- KRS management not advising Ashlar (Paino) of the fire upgrade and safety issues at KRS;
- Jonkar not being advised of the significant fire safety reports, such as the Lumley, Dibben or ULA reports or the Fabric Survey;
- Jonkar not being advised of the renovations to Unit 31 (or at all);
- A fire engineer not being advised about the changing of smoke detectors to thermals in Unit 31 during renovations; and
- Inadequate communication between divisions at KRS of the fire safety issues and recommendations.

Examples of the failure to follow advice are:

- Not following the Lumley, Dibben and ULA reports on maintenance (ULA refers to establishing the Fire Safety Committee and its role in maintenance);
- Not following the Lumley, Dibben or ULA reports on staffing levels in view of the fire safety risk at night;
- Not following the Lumley, Dibben or ULA reports on improvements in evacuation procedures;
- Not following the Lumley or Dibben reports on the importance of the Fire Safety Committee, and in particular, once the Fire Safety Committee was abandoned, in not following ULA's recommendations as to its re-establishment;
- Not following Dibben's holistic approach on the management of fire safety issues;
- Not following ULA on its recommendation as to the need for fire engineering input on renovations or changes to buildings;
- Not following the Ministerial Guidelines on public building renovations;
- Not adequately following government directives on the installation of smoke detectors; and
- Not following the Fabric Survey on its recommendation relating to building renovations.

Examples of the failure to manage the fire risk (where there is clear knowledge of risk and a failure to act) are:

- Not following some of the advice in the various reports (note in substance that it is recognised that the advice on the upgrade was followed);

- Not undertaking an assessment of the 'likelihood of fire' in view of the number of MFB attendances at KRS;
- Not adequately managing the fire-lighting risk;
- Not examining the maintenance contract and the contractor's work in light of a continuing '*lack of faith* in [the] *system*';
- Not adequately examining the Building Code of Australia and/or the Australian Standards for compliance with the system, maintenance and building issues;
- Not adequately involving the maintenance contractor in the upgrade (or renovation) process;
- Not seeking advice from the PCG, the Gardner Group or ULA on fire safety and the 1995 renovations to Unit 31;
- Not adequately considering the consequences of the 1995 renovations to Unit 31 for fire safety management issues; and
- Not managing the return of the residents into Unit 31 after the renovations were completed (and before the upgrade) in light of a continuing '*lack of faith in* [the] *system*' and an awareness of the risk.

In this context of overall failure, no one consultant or contractor can be said to have contributed to the deaths of the nine residents despite any individual performance shortcomings that have been identified. Both historically and practically, the State of Victoria through its various agencies always was the party best equipped to source, scrutinise and disperse acquired learning as to the adequacy of the KRS fire safety systems. It also had a monopoly on final decision-making about how advice was implemented and as to what system was to be adopted for capital expenditure assessment and maintenance audit. As such it was the only party ultimately in the driver's seat.

PART 7 STATE OF VICTORIA'S (DHS) ACKNOWLEDGEMENT OF DEFICIENCIES

The State of Victoria acknowledged a number of deficiencies in its systems operating at KRS. This Part details those acknowledgements, which cover fire detection and prevention systems, training and evacuation procedures. Other areas of deficiencies acknowledged are in managing fire-lighting risk, record keeping and training to identify and manage fire risk. The acknowledgements were made in the early and closing stages of the inquest.

The importance of the early recognition and acknowledgement of deficiencies for both the future prevention of similar systems failures and in the efficient management of the inquest investigation is discussed.

7.1 INTRODUCTION

During the running of the inquiry, counsel for the State of Victoria acknowledged deficiencies in Departmental (DHS) procedures and systems in existence at KRS at the time of the fire. The first of these acknowledgments was read into the transcript on 31 October 1996 and the second by a document dated 9 April 1997. This approach was appropriate and must be commended as the identification of procedural and systems problems at an early stage (and before completion of an inquest) is important to ensure safety problems are addressed. As was observed by the State Coroner in the Sims Metal Case:

> *The coroner's process is but one method of providing public warning and recommendation to avoid the repetition of unnecessary tragedy.*
>
> *There are many government agencies with warning and safety responsibilities in particular areas. In this case within three or four months from 30 September 1986, the Department of Labour has attended every relevant smelter premises in Victoria to ensure no immediate repetition of the type of explosion the subject of the inquest.*
>
> *It is a matter of good sense and judgement as to how warning is given prior to completion of a coroner's investigation.*
>
> *It would be embarrassing and contrary to public responsibility if further tragedy occurred during the course of and prior to completion of a coroner's investigation simply because warning had not been given prior to the completion of the coroner's work.*[1]

In the Sims Metal Case, four deaths occurred in Melbourne in 1986 during processing of aluminium when sodium nitrate was mistakenly added to the furnace instead of sodium chloride (common salt) and resulted in a massive explosion.

In addition, the adoption of this course by the DHS saved a considerable amount of time during the inquest investigation process. However, while the appropriate recognition of systems failures and the development of solutions are an important outcome of the inquest, this approach is to be encouraged. It is also noted that the State of Victoria in its Submission in Reply conceded that the evidence:

1 Coroner's case file no. 863/86, December 1987.

appears to establish that successive governments, government departments involved in the management of the complex or responsible for the undertaking of major capital works or for the maintenance of the system, those familiar with the general condition of government buildings in such institutions, local government and in particular the Kew Council, the Metropolitan Fire Brigade, the "community visitors" to KRS, the Parents' Association, those familiar with the publicity associated with the Willsmere Inquest, and many others ... were aware that the fire protection system was less than adequate at KRS.[2]

It suggests that responsibility for past inaction '*can be said to be that of the community at large*'.

However, the State of Victoria has accepted responsibility in another key area – delays in funding.[3] This issue is considered in the Findings in **PART 3 Management of Risk and System Deficiencies 3.3 Funding Delays in Addressing Fire Safety at KRS.** The State of Victoria points to the fact that due '*recognition ought to be accorded to the present government and DHS for the fact that an upgrade process was initiated within less than twelve months of the new government being elected and DHS being created*'.[4] This is accepted and is covered in other sections of the Findings and in the Comments and Recommendations.

7.2 FIRE DETECTION/PREVENTION SYSTEMS, TRAINING AND EVACUATION PROCEDURES

On 31 October 1996, counsel for the State of Victoria (DHS) read a number of matters into the transcript.[5] As well as commenting on the upgrade, it was acknowledged that:

[t]he Department agrees that fire sprinkler systems, as recommended in the August 1994 Fire Safety Audit, used in conjunction with early warning smoke detectors would reduce the spread of fire and enhance safety levels for building occupants. It is for these reasons that the Department had determined to implement those recommendations.

The Department was in the process of upgrading the fire protection systems at Kew in accordance with the audit. At the time of the fire these systems were substantially completed, although not in Units 30/31. The Department accepts that, had such systems been in place at the time of the fire, it is likely that the loss of life would have been reduced or prevented. It is a tragedy that the sprinkler and upgraded early warning systems were so close to completion at the time of the fire.

The Department acknowledged that emergency documentation and evacuation procedures required improvement at the time of the fire, although it did submit that the identified deficiencies had no impact on the cause and events surrounding the fire.

Under the heading '*Fire manual, evacuation drills and training, and the availability of client lists and floorplans of residential units'*, the Department admitted that the fire manual *'included general reference material and the language and presentation of issues were more akin to a reference guide'*. Further, the Department admitted that:

2 State of Victoria Submission in Reply, pp. 20-21, para. 3.1.

3 State of Victoria Submission in Reply, p. 261 et seq. (see especially para. 8.3).

4 State of Victoria Submission in Reply, p. 21, para. 3.1.

5 Transcript, pp. 1102-1106, by Senior Counsel, Mr R. Redlich QC. There is considerable additional detail in the acknowledgements in the Transcript.

[f]ire evacuation drills and training were not comprehensive and did not cover all contingencies. Although the number of false alarms at the facility and the corresponding evacuations provided staff with a range of practice, it is acknowledged that they are not a substitute for structured and evaluated fire drills.

A roll call was required under the procedures. However, a resident list was not made available to the MFB in the event of a fire. In addition, while a site plan was made available to the MFB, there was no *'accessibility to any schematic floor plans of units'*.

The Department informed the inquest that a new manual was being developed in conjunction with the MFB. Also a statewide emergency manual was being reviewed with help from the MFB and the Country Fire Authority. Resident lists were being upgraded and provided to the MFB. The current three keys system was being replaced with a single master key.

Under the heading *'The handling of client profiles and alerts'*, the Department acknowledged that:

[t]he current information system allows for the placing of an alert on the client file. However current case management practice is silent on how staff should address the issue of any client alert, nor is it explicit on what action staff should adopt if the alert is no longer an issue.

In practice, in the residential setting, staff rely on briefing by other staff as to the relevant behavioural alerts of particular clients, particularly where a client is frequently exhibiting these behaviours. Where these behaviours are not evident, however, this system is recognised as one that is not adequate.

The Department will address this in the development of its new client information system.

On the issue of '*Responses to fire lighting behaviour'*, counsel for the State of Victoria said (on the issue of the Tran inquest) that:

[t]he Department issued statewide instructions to ensure that clients who demonstrated a propensity to light fires were identified and appropriately referred to the MFB Juvenile Fire Awareness program.

Having regard to the circumstances surrounding the fire and the possible perpetrator, the Department believes that the management of fire lighting behaviour is unlikely to have been relevant to the causes of the fire. The Department acknowledges however that, whilst it has sought to implement recommendations made by the Coroner, it needs to develop a more comprehensive response to the early identification and management of clients who demonstrate a propensity to light fires.

This will be incorporated into staff training programs and discussions will be undertaken with the MFB to utilise its expertise in this area and to consider a joint approach to the problem.

7.3 FIRE-LIGHTING BEHAVIOUR, RECORD KEEPING AND STAFF TRAINING: 9 APRIL 1997

The Department's identified deficiencies as listed on 9 April 1997 were as follows:

THE DEPARTMENT OF HUMAN SERVICES: RE CORONIAL INQUEST INTO KEW RESIDENTIAL SERVICES

The following deficiencies in systems and for procedures have been identified as pertaining as at the time of the fire. None of these deficiencies contributed to the cause of the fire.

1. RECORD KEEPING
The Department of Human Services acknowledges that the standard of record keeping in certain areas at Kew Residential Services at the time of the fire required improvement. The approach to the collection, recording and maintenance of information whether current or historical, has not been as comprehensive or accurate as it should have been.

The Accommodation Services Filing System introduced in June 1995 and the new computerised Client information system, currently being introduced, known as "DISCIS" both address client information recording.

The Accommodation File ensures all relevant information in relation to an individual client is contained in one location and that GSPs and IPPs are readily accessible.

DISCIS and the "Assessment of Needs Report" make provision for current behaviours to be recorded as an "alert" and behaviours which are no longer current made "inactive".

2. GSP/IPP STAFF AWARENESS AND SUPERVISION
Department of Human Services acknowledges that at the time of the fire staff at Kew Residential Services had not been as familiar with the contents of clients' files as was desirable and that a more active approach: to dissemination and promotion of client information was required. Furthermore, the preparation of documents was not thorough and supervised as necessary in all instances.

The preparation of all-important documents concerning the client should be thorough and overseen by the Unit Manager. Where the Unit Manager delegates GSP and IPP preparation, the Unit Manager should ensure that the staff member has the necessary skills and that appropriate quality checks are put in place including supervision and "sign off' by the Unit Manager.

A number of initiatives have been undertaken since April 1996 to address these issues:

- *Revamped Unit meeting format which requires an IPP to be discussed at each meeting*
- *Revised Key Worker system which ensures particular workers assume responsibilities for particular clients*
- *Assessment of Need Report and GSP Training for unit managers and deputy unit managers*
- *"Bring Up" system for overdue GSPs to ensure that GSPs are completed without undue delay*
- *Quality "Audits" of units on a random basis by KRS management staff.*

3. HAND-OVER OF MANAGERIAL DUTIES
Department of Human Services acknowledges that in the case of Unit 31 in 1994 that there was not comprehensive hand-over of managerial duties from one Unit Manager to another. This is seen as a reflection of the climate at the time immediately after major industrial action had occurred. It is understood that this climate impacted on relations between staff at the time resulting in a lack of co-operation and comprehensive hand-over.

4. STAFF TRAINING

The Department of Human Services acknowledges that improvements were required at Kew Residential Services in fire safety training and relevant documents such as the Fire Manual and evacuation plans as at the time of the fire.

Further to this acknowledgment, significant improvements have been made both at KRS since April 1996, these include:–

- *New Fire Manual in consultation with MFB.*
- *Standard floor plans and evacuation plans as recommended by MFB.*
- *Regular drill practice (4 day and 2 night per Unit per annum). This has resulted in 114 evaluated drills at Kew since April 1996.*
- *Comprehensive training program – 371 Kew staff have attended Fire Safety and Response Training and 75 staff have done advanced Fire Safety or Fire Warden training. Further training sessions are scheduled.*

5. ASSESSMENT AND MANAGEMENT OF CLIENTS WITH FIRE LIGHTING RISK

The Department of Human Services acknowledges that at the time of the fire the approach to assessing and managing clients who were a fire lighting risk was not as comprehensive or as expansive as required nor was the approach incorporated into the department's systems.

In responding to the recommendations of the inquest into the death of Moc Qui Tran the department's approach was confined to clients who had a known propensity for fire lighting. In following this approach the assessment of clients was limited in scope. While the department generally alerted staff to the need to identify clients with behaviour which may pose a risk it did not adequately systemically embed this approach into some of the main practices and procedures of the department.

Since 1996 the approach taken by the department has been broadened. The approach has addressed the issue on two levels. First the assessment process has now been expanded to include clients who have a known propensity to light fires and now includes clients who are a fire lighting risk due to their reduced cognitive functioning and limited physical independence skills.

Secondly the guidelines and instructions are either now, or soon will be (as indicated below), embedded in the established systems within the department. This more systematic approach includes:

- *Expanded Assessment of Need, which includes prompts for case managers to better assess a clients fire lighting risk (completed).*
- *New Practice Instructions for residential workers to assist them in identifying any risk factors (in the process of being finalised).*
- *Advice sheets for families and residential workers on how to reduce risk by addressing the physical environment and client behaviour (family sheet finalised, staff sheet in process of being finalised).*
- *Identification of service options for clients who have behaviour, which is a fire risk (finalised).*
- *Assessment and planning guidelines have been built into the Induction Training and the Managing Challenging Behaviour Training (finalised).*
- *Negotiations are currently underway to develop a package for staff working in the Behaviour Intervention Support Teams.*

It should be noted that the range of skills and personalities of people with an intellectual disability is as diverse as that of the general community. The objective is to create a situation where staff are aware and informed as well as better skilled to make assessments and develop programs and approaches for the individual.

In implementing this objective the emphasis of the Department has moved from response to those individuals with demonstrated fire lighting behaviour to focusing on the assessment of potential fire risk behaviour. This necessarily includes a much larger group of people who require proactive strategies to prevent actual instances of fire lighting. These strategies may require:

- *Management of the environment such as limited access to, and security of, flammable materials, security of lighters by all smokers and provision of appropriate safety equipment such as smoke detectors, extinguishers and fire blankets.*
- *Safety of appliances used by individuals with greater independent living skills.*
- *Close scrutiny of individuals who collect or hoard items to ensure no hazardous materials are collected.*
- *Referral to appropriate programs to change at risk behaviours such as MFB/CFA Juvenile Fire Awareness and Intervention Program or BIST.*[6]

6 Exhibit 267.

PART 8 LEGAL ISSUES AND CONTRIBUTION

This Part summarises the legislative framework for the Coroner's investigation, and deals with the responsibility of the State of Victoria for the care of the residents at KRS. The responsibility of the State is specified in various legislation: Intellectually Disabled Persons' Services Act *1986; and, as occupier, under the* Wrongs Act *1958. The State also has a common law 'duty of care' for the residents. In addition, a 'duty of care' was owed by the State to the staff working within Units 30/31 under the* Occupational Health and Safety Act *1985. It is noted that KRS staff were injured during the fire. Other staff were put at risk during the evacuation.*

The State of Victoria acknowledges that it has a duty of care to the residents and staff at KRS.

Further, the issue of 'contribution' under the Coroner's Act *1985 is discussed in this Part. Its application in this inquest is determined, and it is found that the State of Victoria contributed to the fire and the deaths of the nine residents.*

Other factors, not amounting to contribution, are also examined. The respective roles of Jonkar, Ashlar and ULA are considered in this context.

8.1 LEGAL ISSUES

8.1.1 INTRODUCTION

Several of the represented parties made submissions regarding the appropriate legal framework within which the findings and facts should be considered. Those submissions have all been assessed and, in some cases, reflected in the ensuing paragraphs. While not purporting to be a definitive treatise on coronial law and contribution, a summary of aspects of the law applicable to this investigation is provided.

8.1.2 INVESTIGATORY FRAMEWORK: THE *CORONER'S ACT* 1985

The *Coroner's Act* 1985 establishes jurisdiction in the coroner to investigate reportable death or fire. Under section 19 of the *Coroner's Act* 1985:

> *(1) A Coroner investigating a death must find if possible –*
>
> *(a) the identity of the deceased; and*
>
> *(b) how death occurred; and*
>
> *(c) the cause of death; and ...*
>
> *(d) the identity of any person who contributed to the cause of death.*

Similar provisions apply to 'fire' under section 36 of the Act where:

> *(1) A Coroner investigating a fire must find if possible –*
>
> *(a) the cause and origin of the fire; and*
>
> *(b) the circumstances in which the fire occurred; and*
>
> *(c) the identity of any person who contributed to the cause of the fire.*

Under both sections 19 and 36, a coroner may comment *'on any matter connected with the death (or fire) including public health and safety or the administration of justice'*. A *'reportable death'* means a death *'that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury ... '*.

8.1.3 APPLICABLE LEGISLATIVE AND/OR COMMON LAW FRAMEWORK

(1) DUTY TO RESIDENTS AT KRS

The State of Victoria owed a positive duty of care to the residents of Units 30/31 and, in particular, to those residents who were killed or injured in the fire. This duty arose:

(i) pursuant to the *Intellectually Disabled Persons' Services Act* 1986;

(ii) pursuant to the occupiers liability provisions of the *Wrongs Act* 1958; and

(iii) at common law as carer and occupier.

(2) DUTY TO STAFF AT KRS

The State of Victoria owed a duty of care to the staff working within Units 30/31 under section 21 of the *Occupational Health and Safety Act* 1985, which provides:

(1) An employer shall provide and maintain so far as is practicable for employee a working environment that is safe and without risks to health.

(2) Without in any way limiting the generality of sub-section (1) an employer contravenes that sub-section if the employer fails:

(a) to provide and maintain plant and systems of work that are so far as is practicable safe and without risks to health;

(b) to make arrangements for ensuring so far as is practicable safety and absence of risks to health in connection with the use, handling, storage and transport of plant and substances;

(c) to maintain so far as is practicable any workplace under the control and management of the employer in a condition that is safe and without risks to health;

(d) to provide adequate facilities for the welfare of employees at any workplace under the control and management of the employer; or

(e) to provide such information, instruction, training and supervision to employees as are necessary to enable the employees to perform their work in a manner that is safe and without risks to health.

(3) NATURE OF DUTY TO RESIDENTS AND STAFF AT KRS

The duty owed by the State of Victoria to both residents and staff at KRS was non-delegable.

Section 4(a) of the *Intellectually Disabled Persons' Services Act* 1986 designates the Minister and the Department as having responsibility to administer the Act. Sections 5(c) and (d) provide:

(c) The welfare of an intellectually disabled person is the first and paramount consideration;

(d) The needs of intellectually disabled persons are best met when the conditions of their everyday life are the same as, or as close as possible to, norms and patterns which are valued in the general community.

Section 5(j) states that it is the responsibility of the State of Victoria to plan, fund and ensure the provision of, and evaluate services to, intellectually disabled persons according to the principles stated therein.

The deceased were all intellectually disabled persons who were incapable of taking care of themselves, and were under the care and protection of the State of Victoria in accordance with the *Intellectually Disabled Persons' Services Act* 1986. They were resident at KRS, which was administered by the Department of Human Services on behalf of the State of Victoria. A legal duty to take reasonable care of the deceased was owed by the State of Victoria at common law and also under the Act.

Section 14B of the *Wrongs Act* 1958 (inserted by the *Occupiers Liability Act* 1983) imposes a duty of care on the State to the staff at KRS. The nature of the duty imposed is flexible, and a determination whether a duty has been discharged involves consideration of the following:

(i) the gravity and likelihood of the probable injury;

(ii) the circumstances of the entry onto the premises;

(iii) the nature of the premises;

(iv) the knowledge which the occupier has or ought to have of the likelihood of persons or property being on the premises;

(v) the age of the person entering the premises;

(vi) the ability of the person entering the premises to appreciate the danger;

(vii) the burden on the occupier of eliminating the danger or protecting the person entering the premises from the danger as compared to the risk of the danger to the person.

8.1.4 CONCEPT OF CONTRIBUTION

The concept of 'contribution' to the deaths and fire in the coronial context requires explanation. As already mentioned, pursuant to sections 19 and 36 of the *Coroner's Act* 1985, the coroner must, if possible, find the identity of any person who contributed to the cause of death or fire. A finding of civil and/or criminal liability is not part of the coroner's role. Moreover, such a finding should not be perceived in the public eye as being part of the coroner's reasoning when a finding of contribution is made. In *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1, Hedigan J stated:

> *On the other hand, one might say the other extreme, the submission was put that the concept of contribution requires no more than the conclusion that there is "some degree of blame" or "blame to some extent." Whilst one is conscious of the difficulties of definition in this sphere, understanding is little advanced by this contention. The width of the proposition, if it can be so described, is such as to comprehend the most remote of influences, including the philosophy of violence containment as well as police culture, training and ideas, all of which attracted the coroner. Generally speaking, the law is cautious about unnecessary exposition of principle ... The issues of causation and contribution have bedevilled philosophers for centuries and have attracted consideration by superior courts in all jurisdictions and places for more than a century. The inclination to expound in an authoritative way, the connection between human behaviour and consequences has proved seductive. The estimation of the nature and extent of this connection may be described as the evaluation of 'contribution'. The law has also espoused minimalism in attempting definition of the causative or contributing effect of conduct.*[1]

Hedigan J develops the 'commonsense' approach to the assessment of causation, and repeats the early comments of the High Court in *Fitzgerald v Penn* (1954) 91 CLR 268 where it was said that it is *'all ultimately a matter of common sense'* and *'in truth the conception in question is not susceptible of reduction to a satisfactory formula'*.[2] His Honour also refers to the High Court

1 *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1, Hedigan J at 16-17.

2 *Fitzgerald v Penn* (1954) 91 CLR 268, the High Court at 277, 288.

decision of *March v Stramare Pty Ltd* (1991) 171 CLR 506 where, in the context of negligence, Deane J said that *'the question of causation arises in the context of the attribution of fault or responsibility whether an identified act or omission of the defendant was so connected with the plaintiff's loss or injury that, as a matter of ordinary common sense and experience, it should be regarded as a cause of it'*.[3]

Hedigan J gives some guidance in rejecting the 'but for' analysis of causation, and reasons, by example, that if it was not for the commonsense approach, '*the armourers who supplied police officers with their loaded weapons could be regarded as contributors'*. However, he is reluctant to put forward a definition, and says that '*it is unwise and unnecessary to attempt to define in the abstract what contribution means in s.19(1). It is preferable to leave evaluation of contribution to be made on a common sense, case by case basis, guided by the general principles to which I have referred'*.[4]

As to the relevant standard of proof required, Hedigan J refers to *Briginshaw v Briginshaw* (1938) 60 CLR 336, in which the 'Briginshaw Test' was formulated, which is the classic formulation as to the appropriate standard of proof to be used in civil cases. The 'test' is:

> *Except upon criminal issues to be proved by the prosecution, it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. The reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the adherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect references ... When in a civil proceeding, a question arises whether a crime has been committed, the standard of persuasion is according to the better opinion, the same as upon other civil issues ... But consistently with this opinion, weight is given to presumption of innocence and exactness of proof is expected.*[5]

In this investigation, the application of the 'Briginshaw Test' would require a high standard of proof when applied to the question of contribution by individuals acting in their professional capacity, such as Paino, Vincent, Lai, Johnson, Cooper, Neicho, Taylor and Vasan. When discussing the 'Briginshaw Test', Hedigan J referred to the cases of *Anderson v Blashki* [1993] 2 VR 89 (Gobbo J) and *Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 (Southwell J). In both cases, the potential of omissions of medical professionals was being considered where a finding of 'contribution' would have serious professional consequences. In summary, both judges concluded, as summarised by Hedigan J, that *'no finding of that kind (contribution) should be made unless there was comfortable satisfaction that negligence had been established as contributing to the cause of death'*. In assessing the position of a police officer under the test, he states that:

> *[t]he present case is different in that police officers are, by the very nature of their professional obligations, put into situations in which the forces of criminal violence are frequently encountered and managed. But the issue of negligence, and the proper carrying out of their duties, still applies in the appropriate circumstances.*
>
> *The identification of the appropriate standards of proof and satisfaction is important, a matter that at all times must be borne in mind by any coroner who has to consider findings*

3 *March v Stramare Pty Ltd* (1991) 171 CLR 506, Deane J at 522.

4 *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1, Hedigan J at 18.

5 *Briginshaw v Briginshaw* (1938) 60 CLR 336, Dixon J at 361-363.

of contribution which must not lightly be made and only be made when there has been established the necessary degree of satisfaction of mind.[6]

He also comments that '*some element of departure from the reasonable standards of behaviour will ordinarily be thought to be required, and must be properly established'*.

In considering the various elements of negligence, it is appropriate to take into account the proximity question, which is whether there is sufficient proximity in the relationship between the parties such that a duty arises and liability exists.[7]

The question arises whether the State's duty of care can be delegated. In *Burnie Port Authority v General Jones Pty Ltd* (1993-94) 179 CLR 520,[8] the High Court summarised the fundamental principals governing 'non-delegable' duty as follows:

> *It has long been recognised that there are certain categories of cases in which a duty to take reasonable care to avoid a foreseeable risk of injury to another will not be discharged merely by the employment of a qualified and ostensibly competent independent contractor. In those categories of case, the nature of the relationship of proximity gives rise to a duty of care of a special and "more stringent" kind, namely a "duty to ensure that reasonable care is taken" (see* Kondis v. State Transport Authority.[9]*) Put differently the requirement of reasonable care in those categories of case extends to seeing that care is taken . . .*
>
> *In* Kondis v. State Transport Authority [10]*; and see also* Stevens v. Brodribb Sawmilling Co. Pty. Ltd.[11] *per Wilson and Dawson JJ., in a judgment with which Deane J. and Dawson J. agreed, Mason J. identified some of the principal categories of case in which the duty to take reasonable care under the ordinary law of negligence is non-delegable in that sense: adjoining owners of land in relation to work threatening support of common walls; master and servant in relation to a safe system of work; hospital and patient; school authority and pupil; and (arguably), occupier and invitee. In most, though conceivably not all, of such categories of case, the common "element in the relationship between the parties which generates [the] special responsibility or duty to see that care is taken" is that "the person on whom [the duty] is imposed has undertaken the care, supervision or control of the person or property of another or is so placed in relation to that person or his property as to assume a particular responsibility for his or its safety, in circumstances where the person affected might reasonably expect that due care will be exercised"* (Kondis v. State Transport Authority[12]*; see also* Stevens v. Brodribb Sawmilling Co. Pty. Ltd.[13] *). It will be convenient to refer to that common element as "the central element of control". Viewed from the perspective of the person to whom the duty is owed, the relationship of proximity giving rise to the non-delegable duty of care in such cases is marked by special dependence or vulnerability on the part of that person (*The Commonwealth v. Introvigne[14] *per Mason J.).*

6 *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1, Hedigan J at 19.

7 See *Gala v Preston* (1991) 172 CLR 243; Sutherland Shire Council v Heyman (1985) 157 CLR 424.

8 *Burnie Port Authority v General Jones Pty Ltd* (1993-94) 179 CLR 520, Mason CJ, Deane, Dawson, Toohey and Gaudron JJ at 550-551.

9 *Kondis v State Transport Authority* (1984) 154 CLR 672 at 686.

10 *Kondis v State Transport Authority* (1984) 154 CLR 672 at 679-687.

11 *Stevens v Brodribb Sawmilling Co. Pty. Ltd.* (1986) 160 CLR 16 at 44.

12 *Kondis v State Transport Authority* (1984) 154 CLR 672 at 687.

13 *Stevens v Brodribb Sawmilling Co. Pty. Ltd.* (1986) 160 CLR 16 at 31, 44-46.

14 *The Commonwealth v Introvigne* (1982) 150 CLR 258 at 271.

In the present case, the State of Victoria is under a non-delegable duty of care because it has *'undertaken the care, supervision or control of the person ... of another'* and *'is so placed in relation to that person or his property as to assume a particular responsibility for his or its safety, in circumstances where the person affected might reasonably expect that due care will be exercised'*.[15] Viewed from the perspective of residents, the relationship giving rise to the non-delegable duty was marked by special dependence and vulnerability on the part of residents.

A submission by the State of Victoria admits that:

> *[t]he concept of non delegable duty, as recent decisions of the High Court demonstrate, is based upon policy considerations that an entity, who may have engaged consultants and independent contractors to discharge its duties, will nevertheless in most circumstances retain an ultimate responsibility for those under its care and control. Public policy has dictated that legal responsibility for the safety and well being of those under its care and control cannot be delegated to others.*[16]

Further, the State of Victoria admits that:

> *it had a personal duty to ensure that reasonable care was taken to provide a safe environment in which the clients could reside. This duty was probably a non delegable one arising from the fact that KRS had undertaken the care, supervision and control of its intellectually disabled clients, thereby assuming a particular responsibility for their safety in circumstances where those clients or their legal representatives would reasonably expect that due care would be exercised for them.*[17]

The State does not concede, however, that it is legally liable in respect of contribution for any and all breaches of duty by its independent contractors.

The State of Victoria also argues that the concept of contribution under the *Coroners Act* 1985 appears to encompass individuals, and not government departments. It submits that:

> *[t]he* Interpretation of Legislation *Act 1984 defines a person as including a body politic or corporate, as well as an individual. Save to the extent that the Department has some corporate existence for limited purposes, it would not be a body corporate nor an individual. A "body politic" as Hedigan J observed in Hallenstein's case at page 43 is "the nation in its corporate character: the State." It is therefore submitted that it is appropriate for the MFB and the Parents' Association to have addressed their criticism to the State of Victoria rather than any individual department.*[18]

The State of Victoria also submits that *'careless references'* have been made to DHS as being responsible for actions that have occurred *'decades before DHS was formed'*.[19]

That reasoning is adopted, and any findings pertaining to contribution are in respect of the State of Victoria.

8.2 CONTRIBUTION TO THE FIRE AND DEATHS

Any contribution by the State of Victoria (or by its agents DHS and/or KRS) to the fire and deaths must be seen in the context of a major upgrade to all of the hardware fire systems which was near completion on the night of the fire.

15 *Kondis v State Transport Authority* (1984) 154 CLR 672 at 687.

16 State of Victoria Submission in Reply, p. 29, para. 3.5.

17 State of Victoria Submission in Reply, p. 219, para. 5.3.

18 State of Victoria Submission in Reply, p. 228, para. 5.21.

19 State of Victoria Submission in Reply, p. 227, para. 5.20.

It is found that:

A. The State of Victoria contributed to the deaths of the nine intellectually disabled residents in three main ways:

(1) The State of Victoria owed a duty of care to the residents under its care to protect them by means of an efficient, safe and proper fire safety system.

The State in its Reply accepts the duty to '*provide a safe place of residence for both its clients and staff at Kew Residential Services (KRS), and in particular, provide a safe residence for the occupants of Flat E, Unit 31'*. This concession on the part of the State of Victoria is a positive step towards addressing and remedying the problems and risks at KRS. It says that it is unnecessary '*to consider that argument that there are other sources of the duty of care as it is not suggested that those duties are more far reaching than the common law duty which the State of Victoria acknowledges*'.[20] It is also put by the MFB in its Submission that '*[t]he deceased were all intellectually disabled persons who were incapable of taking care of themselves and were under the care and protection of the State of Victoria in accordance with the* Intellectually Disabled Persons' Services Act *1986*'.[21]

Despite numerous warnings over the years, the State of Victoria did not provide such an efficient, safe and proper fire safety system, but it must be borne in mind that it was in the process of doing so. This is a finding against the State of Victoria which spans the failure of several governments and their various departments.

The warnings commenced as long ago as 1968 with the six deaths in the Willsmere fire. However, recent history documents warnings from the MFB in 1986, and by a letter from one of the State of Victoria's managers at KRS, Mr Taylor, in 1989:

> *You should be aware that over 750 intellectually disabled people are accommodated at this Centre. Many of these people have profound physical and intellectual disabilities and would be placed at enormous risk in the event of a fire.*
>
> *The management of Kew is not prepared to tolerate any further procrastination on this project. As we have consistently informed the Ministry funding is immediately available to commence installation on a rolling budget basis. Alternatively, and if required, funding for total installation would be pursued through appropriate funding sources.*[22]

In the event that a fire started, especially at night, residents were certainly at '*enormous risk*'. For that reason, it is clear that ten years is too long a period in which to wait to address the many problems with the fire safety system at KRS.

(2) The State of Victoria by its agents DHS/KRS contributed to the deaths of the nine intellectually disabled residents by not providing adequate interim fire safety measures to protect the residents.

(3) The State of Victoria through its agent DHS contributed to the fire and the deaths of the nine intellectually disabled residents by failing to adequately monitor, supervise or manage the fire risk behaviour of one of its residents, Paul.

Implicit in the State's duty to its residents and staff is the responsibility to assess and manage risk and to provide a reliable fire safety system as far as is practicable free of deficiencies.

20 State of Victoria Submission in Reply, p. 218, para. 5.1.

21 MFB Submission, p. 65, para. 133.

22 Exhibit 159 'JT12' – Letter dated 7/8/89.

B. It is likely that Jonkar had a significant and ongoing role in creating or continuing an unsafe fire environment at KRS at the relevant times. It continued to breach Australian Standards and failed to advise KRS/DHS or BSA of the parlous state of the fire safety system it was maintaining. The evidence shows that it continued to replace smoke detectors with thermals as a 'temporary' measure during renovations with the intention of later re-instating smoke detectors. There is no confidence that re-instatement was in fact done.

However, on the required standard of proof, the evidence is not such as to reach that comfortable degree of satisfaction which warrants a finding that Jonkar contributed to the deaths of the nine intellectually disabled residents.

Jonkar's role, while unsatisfactory on many counts, must be seen in context. It must be also noted that Jonkar was not advised of the renovation works so as to enable it to plan for possible interference with the alarm system. It was not given copies of the many reports and surveys on the fire safety system at KRS. Accordingly, while criticism can be directed at aspects of Jonkar's performance, the State of Victoria did not fully and adequately inform, instruct or monitor its involvement, and that failure was significant.

C. It is likely that the respective roles played by ULA and Ashlar were factors in the final stages of a systemic management problem that beset the issue of fire safety at KRS for a number of years. However, on the required standard of proof, there is not that comfortable degree of satisfaction for a finding that those factors were sufficient to lead to a conclusion that either ULA and/or Ashlar contributed to the deaths of the nine intellectually disabled residents.

ULA admitted that it had not sufficiently detailed some areas of fire safety in its 1994 Report. In 1995 Ashlar failed to ask sufficient questions and make the required inquiries about fire safety issues for the planned renovations to Unit 31.

It must be borne in mind that ULA was responsible for providing the necessary technical input to ensure that the upgrade occurred with a sprinkler system. Also ULA was not given a key fire safety report, which had been undertaken the year previously, by CMB.

However, attempts to sheet home contribution ultimately to both ULA and Ashlar ignores the fact that KRS management did not advise one of the renovations and the other of the fire upgrade. At some levels of management at KRS, it was apparently decided (as put by Mr Vasan) to run with the risk:

> *Question: You were conscious, were you, as the works were proceeding, that the building when completed, in accordance with those works, would not meet acceptable fire safety standards?*
>
> *Answer: Yes, at that time, but we know we are going to do the upgrade within months, so it should have been done at that time.*[23]

Apparently, irrespective of the risk, it was decided to wait for the upgrade. The advice given by ULA that a fire engineer should be involved in any future renovations did not operate to affect that choice. That advice was given some 21 months before the fire and ignored in significant respects. The failure of Ashlar to adequately identify fire safety issues must flow from a lack of knowledge of the upgrade and its *raison d'être*. Ultimately, the choice of at least one level of management at KRS was to proceed knowing the risks and banking on the imminent upgrade. Ashlar's work did not affect that choice.

It is the failure to advise both ULA and Ashlar of significant issues relating to fire safety at KRS, combined with inaction on a number of reports, that does not leave that '*necessary*

23 Transcript, pp. 6016-6017.

degree of satisfaction of mind' for a finding of contribution. It must also be remembered that Direct Care management at KRS was not advised of important fire safety issues by other areas of KRS management.

D. In view of the findings of contribution against the State of Victoria, it is unnecessary to make findings relating to contribution in respect of other critical areas of fire safety discussed throughout the body of the Findings. These are:

- Fire drills and evacuation;
- Training; and
- Locking of doors.

Nevertheless, these are important areas which must be seriously reviewed and assessed, regardless of their position with respect to contribution.

FIRE AT KEW RESIDENTIAL SERVICES ON 8 APRIL 1996

COMMENTS AND RECOMMENDATIONS

PART 9

PART 9 COMMENTS AND RECOMMENDATIONS

This Part draws together the key areas where the systemic problems, which played some part in the tragic fire at KRS, developed. Recommendations are made in areas where it is considered that the coronial process can contribute.

The response of many of the parties and, in particular, the State of Victoria, in adopting a constructive focus on the future and prevention is to be commended. The State's response is broad-ranging and goes well beyond the boundaries of KRS. It is essential that the focus move away from criticism to a process of learning from this event to reduce the incidence of injury to the disabled from fire. This incident may also provide other lessons for fire safety in our society.

It is not considered appropriate for the inquest investigation to develop in detail many of the recommendations of the parties in this inquest. Many have appropriately developed the fire safety issues well beyond the jurisdiction of the court. Nevertheless, it is essential that the government agencies responsible for fire safety fully utilise the wealth of expertise that has gone into the recommendations for the ultimate benefit of both the disabled and our society. The parties' recommendations are to be found in Appendices 3 and 4 of the Findings.

Commendations are made to individuals who risked their lives to save others. The work and commitment shown throughout this investigation by the MFB and its Fire Investigation Unit are worthy of comment.

9.1 INTRODUCTION: THE FUTURE

Many of the parties have adopted what the Metropolitan Fire Brigades Board aptly described as a *'prescription for prevention'*.[1] In particular, the submissions of the Kew Cottages & St. Nicholas Parents' Association, the Health and Community Services Union, the Villamanta Legal Service, the Office of the Public Advocate, Wormald, Umow Lai & Associates, the Building Services Agency, the MFB and the State of Victoria have developed a primary focus on learning from this tragic fire. Each brings a particular perspective and contribution to both the inquest and the future. It would be a shame not to use all of the learning acquired during this process to the maximum, not only to address any remaining problems at KRS but also focus on far wider fire safety issues extending well beyond the jurisdiction of the inquest.[2]

The loss to the potential for assisting with development of fire safety systems of the specialist experience of consultants such as Umow Lai and the contractors Wormald, or the broader vision of

1 See MFB Submission, 'frontispiece' to Submission.

2 See *Harmsworth v The State Coroner* [1989] VR 989 where Nathan J found (in summary): *'The State Coroner's power of investigation arises from a particular death or fire. His enquiry must be relevant to that death or fire. The power to comment arises as a consequence of the obligation to make findings and is not free-ranging. It must be comment on any matter connected with the death or fire. The State Coroner may not enquire for the sole or dominant reason of making comment or recommendation'*. This case concerned the deaths of five prisoners who died in the course of a fire that one of them had lit in a cell block. The prisoners had built a barricade, and fire officers and prison staff had been unable to reach them before they were overcome by fumes from burning material. The case resulted from an appeal of the Director-General of the Office of Corrections on the grounds that the coroner *'had exceeded his jurisdiction by admitting into evidence testimony as to a number of matters relating to prison administration and operations'*.

the BSA, would be a mistake. Equally, the invaluable experience of the Parents' Association, the Union or agencies such as the Villamanta Legal Service and the Public Advocate requires detailed consideration. Each provided a substantial and positive input throughout the inquest.

The importance of identifying and rectifying deficiencies following the fire and deaths at KRS has been well recognised by the State of Victoria. It has '*demonstrated*' a preparedness to '*set in place a system of reform before the conclusion of the inquest*'.[3] The reforms are not limited to KRS but will extend to other forms of accommodation provided by DHS and to non-government areas funded by the department. It is noted that the MFB are appropriately involved in the process. Significantly, DHS has developed a '*Fire Risk Management Strategy*' which is discussed in the State's Submissions in Reply.[4]

From about 1993, the government began a program of audits of public buildings and, as evidenced by the work on the upgrade of the fire services at KRS, commenced to address some of the identified problems. In its Submission in Reply, the State of Victoria indicated that it is providing an *'amount of $75.5 million ... to continue the program of fire safety audits and works to upgrade Department facilities over the next three years'*.[5] The funding was announced in the 1997/98 budget and is available '*for the progressive upgrade of fire safety for Department owned or operated buildings. The audits have identified high and medium priority works progressively implemented across the State'*.[6] On any view, the dedication of $75.5 million (over three years) to fire safety at DHS facilities is a massive and unprecedented commitment. It is to be hoped that the planning, implementation and auditing of that program ensures that these funds are well spent.

The State of Victoria (through DHS), in looking towards the future and developing what may be properly called a fire risk management 'model', is to be commended.

Where residents are disabled, elderly or incapacitated, it is essential that the appropriate fire prevention, warning, reduction and evacuation system is employed. Initially, it is important to consider the quality of the building and environs (including materials and layout), products with potential fire risk, furniture and bedding. Fire-lighting or risk behaviour and smoking need to be managed. All fire prevention must start with the aim of reducing the potential for fire to develop. Where work is undertaken on an upgrade of fire systems, the management of safety in the interim is vital. This case is a salutary illustration of that point.

Fire warning and evacuation systems must be developed to cover the needs of the residents, staff and public in the event that a fire develops. Fire reduction and protection systems need to address the ever-present potential for rapid fire conflagration. All of these systems need to consider the disabilities or particular nature of the residents and their environment. In particular, agencies caring for the disabled have a considerable responsibility for their safety.

Without management, fire can spread in an enclosed room (the size of a normal bedroom or living room) to engulf the area to a temperature of approximately 600 degrees Celsius within about six to seven minutes. Smoke and toxins developed during a fire can kill well before that. Fast-response sprinkler systems can douse fires well before a room is engulfed.

Considering the nature of the disabilities of the residents at KRS, a sprinkler system is, and was, one of the only practical ways of providing the best technology to ensure that the risk to life and property was reduced. This fact was obviously recognised by DHS when it commenced work to install a residential sprinkler system at KRS. Tragically, that work was not completed for Building 37 at the time of the fire.

3 State of Victoria Submission in Reply, p. 46.

4 See Appendix 3.2 of the Findings.

5 State of Victoria Submission in Reply, p. 48, para. 1.6.

6 State of Victoria Submission in Reply, p. 57, para. 2.8.

The need for sprinkler systems at KRS was well identified as far back as 1968 by fire brigade reports and confirmed by many subsequent reports. While it must be clearly acknowledged, to the credit of DHS, that sprinklers were in the process of being installed, the inevitability of the type of event under investigation was well flagged by the number of fires and audits. The hazard was well identified and the risk, while in the process of being addressed, was not appropriately managed in the interim. A total systems approach was not taken. In spite of that observation, the State of Victoria (and DHS) by reaching the conclusion that a sprinkler system was necessary must be commended. The upgrade of KRS's fire detection system to an addressable system was also appropriate. Unfortunately, that capital commitment had been side-stepped despite numerous warnings over the years.

The Public Advocate delivered further submissions drawing attention to the recent New South Wales Audit Office's *Performance Audit Report – Large Residential Centres for People with a Disability in New South Wales* (1997). The Public Advocate highlighted the comment in the Audit Report that:

> *there is no policy for government residential facilities regarding procedures for identifying and minimising fire risk (such as the need to have evacuation procedures or conduct regular fire drills). The result has been varied approaches to reduce fire risk which include:*
>
> - *annual fire safety audits*
> - *fire alarm systems linked to the local fire stations*
> - *use of smoke detectors*
> - *training of staff in the use of fire fighting equipment*
> - *fire evacuation procedures and regular fire drills.*[7]

The New South Wales Audit Report also makes the observation that the '*Department of Community Services recently reviewed its large residential centres against the requirements of the Building Code of Australia. The report indicates that the conditions of the centres (in respect to fire safety) ranged from poor through to complying with the Code. Findings included an absence of appropriate fire detection or alarm systems and little fire compartmentation in accommodation areas*'.[8] This report only serves to add to the demonstrated need for our society to work towards improving protection for the disabled from the devastating effects of fire.

The work being undertaken by the State of Victoria (with DHS) is a major step in this direction. The work of the MFB, BSA and others involved in this inquest are invaluable tools to ensure that the potential for a repetition of this type of event is minimised.

9.2 SPRINKLERS WILL SAVE LIVES

There is no doubt that sprinklers will save lives. The disastrous fire at KRS has been recognised as highlighting the value of automatic sprinkler systems. It should be a salutary lesson that sprinkler systems have been utilised successfully in buildings in Australia for about 100 years.

7 Audit Office and Community Services Commission of New South Wales, *Performance Audit Report – Large Residential Centres for People with a Disability in New South Wales* (1997 – published by the Audit Office of New South Wales), p. 59.

8 Audit Office and Community Services Commission of New South Wales, *Performance Audit Report – Large Residential Centres for People with a Disability in New South Wales* (1997 – published by the Audit Office of New South Wales), p. 59.

The issue of the safeguarding of life in buildings by automatic sprinkler systems is considered by H. W. Marryatt in *Fire: A Century of Automatic Sprinkler Protection in Australia and New Zealand 1886 – 1986*.[9] Following an analysis of the 100 years of experience of sprinkler systems in Australian buildings, the author comments that:

> *[a]utomatic sprinklers, properly installed and maintained, are the most effective of any of the various safeguards against loss of life by fire ... records of loss of life by fire show that in sprinklered buildings fire fatalities have been at a minimum. Automatic sprinklers are particularly effective for life safety because they give a warning of the existence of fire, and at the same time apply water to the burning area.*

Further, he states that:

> *loss of life in sprinklered properties has been small compared to that in unsprinklered properties. Inhalation of hot gases has been responsible for many fire deaths. Sprinklers can detect and control fire effectively before hazardous heat, smoke and gas conditions are greater. Not only are the lives of workers protected but also the lives of fire fighters.*[10]

The MFB submitted (and is supported by the experts and the parties) that the 'fire test' established that:

> *if a sprinkler system had been installed the fire would have been extinguished in the compartment of fire origin by the sprinklers between about 190 seconds and 330 seconds of ignition. This would have been well prior to the onset of the untenable conditions seen in the final resting places of the deceased and in time for the evacuation of them all. The outcome of the fire thus conclusively demonstrates the fundamental truth that sprinklers save lives. The known risk of loss of life from fires in residential care facilities can all but be eliminated by the installation of automatic sprinkler systems.*[11]

The MFB remarked in its Submission that '*[i]t is salutary to note that the nine people who died in the fire at KRS constitute three times the number who have died in residential type accommodation fitted with sprinkler systems in the last 100 years*'.[12] The MFB Submission also emphasised the need for sprinklers in areas where security of clients is an issue, saying that:

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9 Marryatt, H. W., *Fire: A Century of Automatic Sprinkler Protection in Australia and New Zealand 1886 – 1986* (Revised Edition, 1988, published by the Australian Fire Protection Association in co-operation with the National Fire Protection Association International and National Fire Sprinkler Association Inc USA), see especially Chapter 7.

10 In *Fire: A Century of Automatic Sprinkler Protection in Australia and New Zealand 1886 – 1986* (Revised Edition, 1988, published by the Australian Fire Protection Association in co-operation with the National Fire Protection Association International and National Fire Sprinkler Association Inc USA), H. W. Marryatt analysed the 389 recorded fires which occurred in residential and institutional type premises protected by sprinkler systems (at pp. 194-196). The conclusions in relation to these fires are at p. 196 and state:

It will be seen that in the 389 fires in these residential and institutional type occupancies, 100% were controlled. There was fire brigade action in 54 fires (16%). The highest average number of sprinklers in operation was 1.71 (the majority of fires (88%) being controlled by one sprinkler head in operation) and there were three fatalities. One of these involved an elderly woman in an institution, who suffered fatal burns when she dropped a lighted cigarette into a rubber upholstered arm-chair. Another victim was a young woman in a mental hospital, who ignited her clothing while smoking. She ran from the room and sustained fatal burns. The bed clothes of an elderly woman in hospital were ignited when hot metal from an exploding fluorescent ceiling light fell onto the bed. She suffered fatal burns. Prompt sprinkler operation in all cases meant that there was no danger to the other occupants.

11 MFB Submission, p. 115, para. 205.

12 MFB Submission, pp. 111-113, para. 200.

[i]f it is necessary for residential care facilities to be provided on a secure basis then it is critical that automatic sprinklers and a local alarm system be provided in such premises.[13]

Further, some concern was voiced about the issue of partial sprinklering (of the type that was being installed at KRS). The MFB notes that the ULA Report gave two costings for sprinkler systems:

Note that two estimates are given, one for providing sprinklers to the dormitory or sleeping areas in each unit only, for life safety, and one for sprinkler protection to the entire building for each unit, both for life safety and asset protection.[14]

Apparently, the partial sprinklering estimates were provided at CMB's request. The MFB commented that Marryatt analysed loss of life in partial sprinklered premises thus:

These authorities have been quoted at length to demonstrate the fundamental importance of complete automatic sprinkler protection within a fire section if the successful extinction or control of fire is to be achieved. An automatic sprinkler system is not designed to cope with fire originating in a part of the same building which does not have sprinkler protection. Although complete protection is axiomatic, there has always been, and continues to be a tendency to attempt to select the spots in a building where fire is likely to break out, and to ask for automatic sprinkler protection only in those areas. That this is a completely fallacious view has been demonstrated time and again and it was a factor in one of the largest industrial fires on record where approximately 20% only of a large building had automatic sprinklers and the fire broke out in an unsprinklered area. Even as late as 26 years after this fire, there was a major fire in an hotel with partial sprinkler protection in which there was heavy loss of life, again because the fire originated in an area without automatic sprinkler protection. There is little doubt that a major factor in the performance of automatic sprinkler systems in Australia and New Zealand is that in by far the majority of buildings, installing contractors, insurance underwriters' associations, fire brigades and other authorities have co-operated to ensure that as far as possible this important aspect of sound automatic sprinkler system design was observed.[15]

By example, the MFB relates the partial sprinklering of one of the units at KRS. Sprinklering is not reliable:

where the system is partial only. For example, the situation revealed in the evidence as regards Units 7/8 is extremely disturbing. This is a two-storey unit with a kitchen downstairs and bedrooms upstairs. Only the bedrooms upstairs are sprinklered. Emergency escape is via a set of stairs which is not smoke separated from the downstairs kitchen area were there is a significant risk of fire (see T4891). While the example of Unit 7/8 is particularly troubling, there is generally no fire separation between sprinklered and unsprinklered areas in the units at KRS. There is a serious risk of loss of life.[16]

In conclusion, the MFB states that '*to be effective the coverage of sprinklers in residential care facilities must be complete. The only alternative to complete sprinkling is fire separation of the compartments in the building*'.[17]

By providing for the installation of sprinkler for all of Units 7 and 8 at KRS, it is clear that DHS has appreciated the difficulties of partial sprinklering in this type of environment. This action is being taken in spite of the fact that the unit is earmarked for closure.

13 MFB Submission, p. 117, para. 208.

14 See MFB Submission, discussion at p. 117, para. 209. See also Exhibit 143, p. 19.

15 MFB Submission, p. 118, para. 210.

16 MFB Submission, pp. 117-118, para. 211.

17 MFB Submission, p. 119, para. 212.

The State of Victoria noted that Regulation 5.15 of the Building Regulations 1994 (which came into operation on 1 August 1997) requires that AS 2118.4-1995 sprinkler systems be installed in all defined residential care buildings within five years.[18]

RECOMMENDATION 1

Full fast-response residential sprinkler systems for buildings housing the intellectually disabled is supported. Partial sprinklering is not.

Moves towards a phased compulsory introduction of residential sprinkler systems for buildings housing the intellectually disabled is also supported.

When the issue of mandatory requirements for residential sprinkler systems is considered, the elderly, the sick and the disabled are recognised as being in areas of high risk. Over the years, coroners have made a number of recommendations for sprinkler systems in these areas. Accordingly, the requirement for the mandatory introduction of automatic sprinkler systems in residential care facilities is supported.

9.3 AUDIT REPORTS: NEED TO DEFINE AND MANAGE

9.3.1 NEED FOR REGULAR FIRE AUDITS

The need for regular fire audits has been well canvassed in the recommendations of the parties involved in this inquest. The benefits of a regular and systematic audit process are obvious. The failure to review regularly fire safety and management systems can only operate to increase the potential for exposure and risk of any agency to disastrous fire. As procedures become too entrenched in daily work life or hardware begins to become obsolete, the need for regular audit increases.

In this inquest it could not be said that the problem was one of a lack of reporting. The problem was, when looking at the totality of the reports, that many of the recommendations were ignored. The totality of the recommendations in the various reports was not managed.

9.3.2 NEED TO DEFINE

The confusion associated with audits and the precise extent to which the reports operated to affect the decisions on fire safety in this incident is a moot point. Certainly, the need to define the operational limits of particular types of audits has been identified.

The failure by a branch of DHS to act on all of the recommendations in the 1993 Dibben Report was a critical factor leading to some of the systemic problems surrounding this fire. Many of the pertinent recommendations in the Dibben Report were not acted on because the report was incorrectly considered to be 'technically flawed'. This reasoning may have flowed partially from a lack of appreciation of the holistic approach being adopted by Dibben. It may have resulted from a lack of understanding of audit methods. The failure to supply that report to ULA is also a factor.

Where a governmental or private agency requests an audit, there is a need to specify its operational limits clearly. This cannot be done accurately without knowledge of the basis on which a particular type of audit is conducted. In this regard, it is essential that the fire protection industry assist the community and provide definitions and extent of coverage of particular types of audit.

The recommendation of ULA that Standards Australia develop a Standard '*governing the scope and methodology of the various types of fire audits'* is supported. The Australian Fire Authorities Council and the Australian Fire Protection Industry should be involved in the process.

18 State of Victoria's Response to the MFB's Recommendations, para. 9.

RECOMMENDATION 2

That Standards Australia (with the fire protection industry) develop a Standard governing the scope and methodology of the various types of fire audits.

9.3.3 AN 'AUDIT TRAIL'

In undertaking any audit, there is a need to review all earlier consultants' surveys and/or fire audits/ fire reports to assist in determining the extent of risk and to identify where previous problems have not been rectified. In this case at least one of the reports – Dibben – was effectively shelved. This broke any possibility of continuity between the various reports, thereby increasing the risk of crucial issues being missed in subsequent reports. There was no audit trail linking the various documents.

It might be that the review process involves a two-stage process. No doubt there are circumstances where, at least initially, a wholly independent consulting overview is called for, uninfluenced by the thinking adopted in earlier studies. Should that be the case, perhaps the preliminary draft report from the reviewing consultant be made available and then reviewed incorporating consideration of the earlier reports. Either way, the knowledge gained from various reports over time must not be lost.

Management has a clear role in drawing these documents together to assist in the process of fire audit. Where an earlier report has been done, it is essential that it be supplied to the consultant undertaking the audit. Also management needs to document responses to recommendations.

When the development of an 'audit' standard is being considered by Standards Australia, there is a need to ensure that reports affecting fire safety are linked. An 'audit trail' between the various reports is essential to minimise the risk of issues remaining unattended.

RECOMMENDATION 3

Any standard for audits developed by Standards Australia should include a requirement for a consultant to review previous audits, fire reports and consultants' surveys.

RECOMMENDATION 4

Any standard developed by Standards Australia should include a requirement for management to supply previous audits, fire reports and consultants' surveys to the consultant undertaking any audit or survey.

9.3.4 NEED TO MANAGE AUDIT REPORTS AND RECOMMENDATIONS

This inquest has demonstrated the need for a managed 'audit trail'. To assist in that process, sound management practice would dictate that copies of all fire audits, reports, surveys etc pertaining to one building or complex be kept together. This would assist in subsequent review or audit process.

The need to manage recommendations has also been demonstrated. Numerous recommendations of reports and surveys were not addressed. Thus any standard dealing with audits may need to specify mechanisms for managing the recommendations. That does not mean, however, that audit recommendations are required to be followed. What is necessary is to establish a system for appropriately considering and documenting responses to recommendations flowing from audits.

RECOMMENDATION 5

Any standard developed by Standards Australia pertaining to audit methodology should include a requirement that management ensure copies of all audits, reports and surveys pertaining to fire safety issues be kept in one file relating to the relevant complex or building.

RECOMMENDATION 6

Any standard for audits developed by Standards Australia should include a requirement for management to document, assess, review and report periodically on the various recommendations contained therein.

9.4 MAINTENANCE: 'CONTRACTING OUT' AND THE REQUIREMENT FOR 'AUDIT'

At KRS the maintenance contractor performed its work for a number of years with no technical supervision. KRS considered that the maintenance contractor's work was being overseen by the government building services agency (BSA). Apparently, while both BSA and DHS knew that this was not the case, the client KRS was not advised. The agreement between the contractor and BSA specified compliance with Australian Standards in the maintenance work. That agreement was also ambiguous as to whether 'technical audits' would be performed.

The fire and subsequent investigation disclosed numerous breaches of Australian Standards. Those breaches included regularly exchanging smoke detectors with thermals (allegedly on a temporary basis). Safety was compromised in a number of areas. With no 'technical audit' of the contractor's performance, the potentially unsafe situation continued.

While performance-based maintenance of essential services (including fire safety equipment and services) is specified under the Victorian Building Regulations 1994,[19] without some form of independent checking, the risk of a repeat of the KRS situation cannot be eliminated. It is understood that the Institute of Engineers and the Australian Fire Safety Practitioners' Accreditation Board are developing competency requirements for those maintaining fire safety systems. Nevertheless, where fire safety is concerned, an independent 'technical audit' of a maintenance contractor's work is essential. It may be necessary to consider requiring that an independent 'technical audit' of maintenance contracts be built into the Australian Standards.

RECOMMENDATION 7

An independent 'technical audit' should be part of any maintenance contract of fire safety systems. While it is recognised that a 'technical audit' of maintenance may not be a regular occurrence, a system should be developed to ensure that maintenance work is checked.

If appropriate, a provision should be inserted into the relevant Australian Standards requiring an appropriate level of independent 'technical audit' of maintenance contracts and works.

9.5 INTERIM SOLUTIONS: AN INDUSTRY STANDARD OR CODE

During the inquest the MFB developed an example 'Fire Detector System' inter-locked to 9 volt smoke alarms. The system was designed and demonstrated approximately two weeks after the issue of low cost interim measures was raised at the inquest. The design of the system provides that:

19 Victorian Building Regulations 1994, PART 11 – Maintenance. This part specifies areas such as exit doors; Fire Brigade connections; fire control centres; fire control panaels; fire curtains; fire dampers; fire detectors and alarm systems; fire extinguishers; sprinkler systems; etc. (the fire list is far more extensive).

[e]ach flat may have up to 12 alarms fitted, we have allowed for 8 per flat. Each Group of 8 Smoke Alarms are wired back to a L.E.D. within the office. A panel within that office indicates the area from where the alarm has activated (i.e.: an addressable system). Each group of smoke alarms are also wired to a smoke alarm within the office to provide an audible signal within that area. The operation of the smoke alarm will also sound a remote siren and Strobe light.[20]

The sirens were to be fitted at each end of the building. Strobe lights would be fitted at strategic points in each building. If a smoke alarm operates in a bedroom, all smoke and siren alarms would operate. An L.E.D. light in the office area would indicate the area where the alarm was activated. An additional part of the system included automatic door de-latching devices. They would operate on activation of the system. In addition, the system was designed to provide illuminated strips of directional arrows as a low cost alternative to emergency lighting.[21]

Some of the equipment used in the 'interim system' designed by the MFB was reusable.

The rapid design of an inexpensive interim system illustrates the viability of a problem-solving approach. Unfortunately, our systems of risk management are not conducive to innovative interim solutions. Approval processes are necessary to ensure that the systems work and do not create unforeseen safety problems. That procedure is appropriate; however, with our rapidly developing technology, approval systems need to be in place to ensure that maximum benefits are obtained from any interim technical solutions where improved short-term protection is required pending upgrade.

During the planning and early implement stage for the upgrade at KRS, interim hardware measures were discussed. Once interim hardware solutions were found not to be an option (because they were not low cost, integratable and were not approved), other management solutions were not considered. A broader 'holistic' approach to the management of risk and the introduction of non-hardware interim solutions was not taken. These may have included staffing levels at night, improved evacuation procedures, managing fire-lighting risk or even in not returning the residents to Unit 31 until the upgrade was complete.

There was clear knowledge of the risk to residents and staff and an awareness that the upgrade would take some months to complete. At the least, there was to be an interim period of seven months (from construction start to completion). After the delivery of the ULA Report, a 21 month lead-time had developed by the time the fire occurred. In these circumstances interim solutions were necessary. The later alteration to Unit 31, dividing it into flats, increased the difficulties for staff in the supervision of residents and emergency management. This made interim solutions even more necessary.

The experience of the fire at KRS has highlighted the need for the fire protection industry to be aware of the various types of interim solutions available (hardware or management). Systems need to be developed to fast-track approval procedures for interim hardware solutions in appropriate cases. It is noted that the State of Victoria is including an 'interim works clause' in the standard brief for fire audit and fire risk analysis.[22]

The MFB makes a telling point in its recommendations:

The Fire Protection Industry must change their philosophy in relation to interim systems. Whilst acknowledging that it is the responsibility of fire engineers to develop appropriate

20 Exhibit 166. The cost of the system was put at $1349.65. A vibrating pad for the hearing impaired was costed at $50 each. The supply and fitting of a magnetic door latch was costed at an additional $1250 per door. The total cost per accommodation unit was put at $2799.65 (which includes four vibrating pads and one magnetic door latch system). The system can be viewed at the MFB (Fire Investigation Unit).

21 See Exhibit 166.

22 See Appendix 3.2 of the Findings, para. 2.38.

interim systems, it seems that there is a consensus view among fire engineers that the interim systems must comply to standards or be elaborate in nature. This is not the point – interim systems are there to provide short term corrective measures for otherwise deficient systems and may comprise of simple measures. They are not meant to bring systems up to standard – a full fire upgrade may be necessary for that.[23]

Further, the MFB suggests that:

[a] discussion paper on the role of interim or corrective measures should be developed (the Fire Services should have input into the development of such a document) so as to spark industry discussion as to the development of the interim measures philosophy.[24]

RECOMMENDATION 8

That Standards Australia (with the fire protection industry) develop a standard governing the scope of interim hardware (or technical) solutions; or
the fire protection industry develop a code governing the scope of interim hardware (or technical) solutions.

(Any standard/code developed should stress the need to consider other interim management solutions.)

RECOMMENDATION 9

Where approval of the technical specifications of an interim hardware solution is required, a fast-tracking system should be developed.

All relevant approval agencies need to be identified and involved in the process.

9.6 A SYSTEM FOR FIRE AND EVACUATION PROCEDURES

The need for adequate systems to prevent or manage fire and evacuation procedures for the intellectually disabled is obvious. This is illustrated by the following exchange between counsel for the MFB and Leading Fire Fighter Snowden:

Question: (Had Fire Officer Kelly) ... discussed the reasons why it was such a high risk area?

Answer: From my experience I realised it could possibly be a high risk area.

Question: Was that partly because of the high occupancy of buildings with residents?

Answer: No. I would suggest it was because of the clients themselves.

Question: So the fact that because of their disabilities it was going to be a much more difficult job to evacuate them and account for them in the event of a fire?

Answer: Commonsense would say that.[25]

One could only agree with these comments.

23 MFB Recommendations, para. 73 (see Appendix 3.3 of the Findings).

24 MFB Recommendations, para. 73 (see Appendix 3.3 of the Findings).

25 Transcript, pp. 576-577.

Fire crews commenced an immediate attack on the fire and, based on information supplied by persons that identified themselves as staff of the Kew complex, initially believed that they were dealing with a fire fight only and that all occupants had been evacuated from the complex.

As the incident unfolded, it became obvious that not everyone could not have been evacuated as there were still residents and staff milling around Building 37.

The incident controller, confronted with a major building fire combined with an unknown quantity of missing persons called for additional Brigade resources to be dispatched.

It wasn't until almost 26 minutes had passed that it could be established that as many as 10 residents could be missing.

This fire reflected the need to ensure that those charged with the care of others follow a predetermined plan of action, established by clear concise and workable emergency procedures. It is also important that the procedures be practiced by those expected to implement them.[26]

The State of Victoria (DHS) has appropriately developed a system to deal with fire drills and evacuation in departmental premises.[27] It is noted that Australian Standard AS 3745-1990 'Emergency control organization and procedures for buildings' is referred to in the response to the Parents' Association recommendations. The State indicates that its protocols largely comply with the standard. AS 3745 provides guidance on:

the establishment of an Emergency Control Organization (ECO), sets out recommended procedures for the safety of people in buildings during emergencies and addresses the authority of the ECO personnel.[28]

However, there is no reference in the evacuation procedures to the Australian National Competency Standard Competency Standard CS-FP-001-1995. If this standard has not been used in the development of the protocol, it may be appropriate to re-consider the issues in light of the standard.

RECOMMENDATION 10

That DHS examine the application of the Australian National Competency Standard – Competency Standard CS-FP-001-1995 for fire emergency response.

9.7 MANAGEMENT: RESPONSIBILITY TO MANAGE RISK

The fire at KRS has highlighted the fact that management should be aware of its responsibility to manage fire risk. In this case management failed to consider thoroughly and address appropriately all of the recommendations of the fire brigade and consultants. Simply put: management was adequately informed of the fire risk but failed to manage it. Reliance was placed on the imminent upgrade, and so other safety issues were largely ignored. By way of illustration the Fire Safety Committee at KRS was effectively disbanded with the knowledge of management.

26 MFB Report, p. 202.

27 See Appendix 3.2 of the Findings.

28 Australian Standards – Index.

RECOMMENDATION 11

That the State of Victoria consider reminding public sector managers of the general responsibility to manage fire risk. This could be addressed through regular management training programs and government publications.

The lessons learnt from the KRS fire need to be reinforced in the area of public sector management.

9.8 FAST-TRACK FUNDING

Where a fire audit or investigation indicates major safety concerns over a number of years, it is essential that funding issues be prioritised. Where concerns are combined with areas of moderate to high risk and a degree of urgency, rapid access to funding becomes a crucial issue. It may be necessary to consider methods of balancing competing priorities to provide a mechanism of 'fast-track funding' for major fire safety issues. It is essential that delays in this area be minimised.

The State of Victoria in its Reply has recognised the importance of improving the speed of access to funding in the area of fire safety by its comment:

> *The delay in the obtaining of a fund allocation from the time that Mr. Taylor first submitted the upgrade as a priority capital works project should be a matter of justifiable concern. The State of Victoria accepts much of the criticism that has been raised by various parties concerning this delay. The functioning of government and the bureaucratic process accounts for much of this delay. The State of Victoria recognises that the constructive criticism that has been raised will lead to the reform of some of these processes.*[29]

One of the methods of reducing delays proposed by the State of Victoria is to establish a register of 'Fire Engineers for Audits and Fire Risk Analysis'. There may well be others specifically applicable to funding procedures.

RECOMMENDATION 12

The State of Victoria consider procedures to improve the speed of access to funding where major fire safety issues are concerned.

9.9 BUILDING ISSUES

The MFB in its recommendations echoes the concerns of a number of the parties to the inquest when it said that:

> *[t]he deficiencies in the consideration and implementation of the renovations resulted in part from inadequacies in the building regulations regarding premises used for the provision of residential care accommodation and regarding the renovation of such premises.*[30]

There was confusion over the building classification of facilities such as KRS, but it was said that:

> *the real problem identified in the inquest is the pressing need for the reform of the BCA so that the fire safety requirements of residential care facilities are properly prescribed.*

The MFB suggested that:

29 State of Victoria Submissions in Reply, pp. 261-262, para. 83.

30 MFB Recommendations, paras. 70-71 (see Appendix 3.3 of the Findings).

[t]his should be done through a consultative approach. And must include a requirement for sprinklering. These requirements must be incapable of waiver and apply to Government buildings as well as private buildings.

Certainly, the State of Victoria has been moving down the path of reform in the area of building law as it applies to the public sector and safety. It is worthy of note that as from 1 August 1997 government buildings are subject to the provision of the *Building Act* 1993. This is a commendable initiative, remedying what must have presented to onlookers as a most peculiar dispensation.

In regard to future improvements, the Warrington Report also comments:

9. 11 It is also noted that the limitations with the existing BCA have been partially addressed by the release of a performance based BCA and will be further addressed by amendments to planned modifications to the Victorian Building Regulations to be implemented in 1997 providing additional requirements for facilities similar to Kew Cottages.[31]

However, Warrington cautions that:

9.12 The planned modifications to the building regulations will not address more subtle design considerations for fire safety such as fire prevention through the use of flame retardants, simple building layouts to facilitate ready evacuation and well illuminated sheltered assembly points for evacuation, and may not address the limitations of the current classification system.[32]

It is essential that these subtle difficulties be overcome.

RECOMMENDATION 13

That a consultative process be adopted to ensure that any anomalies or difficulties in classification of residential care facilities under the* Building Act *1993 be overcome.

RECOMMENDATION 14

That a consultative process be adopted to ensure that any fire safety problems associated with residential care facilities and building law be overcome.

The KRS fire highlights the need for caution by building surveyors when dealing with fire safety issues in the public or private sector. The difficulties associated with construction or alteration to buildings housing the intellectually disabled add to that requirement for caution.

There are a number of recommendations by the parties which direct attention to the need for added education, training and improvements in procedures for building surveyors. With changes in governmental regulations for fire safety in public buildings and performance-based requirements, these are endorsed as an important step in fire safety.

9.10 FIRE SAFETY AND 'CONGREGATE CARE'

The Office of the Public Advocate indicated concern about the fact that '*the characteristics of congregate care inevitably and foreseeably deleteriously affect the safety of dependent, long term residents with intellectual disabilities'*.[33] He points to the fact that it is fundamental to consider the

31 Exhibit 201, p. 28.

32 Exhibit 201, p. 28.

33 Public Advocate's Submission, p. 34.

physical '*environment within which the care is provided'*.[34] Although the issue of the desirability or otherwise of congregate care is not within the jurisdiction of the inquest,[35] that issue has been raised in the context of fire safety. As is put by the Public Advocate, the grouping of large numbers of *'residents in one another's company in congregate care units such as Unit 30/31'* has an *'immediate safety outcome'*.[36] It leads to dependency of the residents on the carers and further:

> *[t]he awful reality of the fostering and reinforcement of dependency in congregate settings at levels which are convenient but not necessary is that residents' capacity for decision making or the taking of initiative in circumstances of emergency is reduced. The risk is that the response of residents in times of stress or difficulty will be one of freezing, rather than any form of self-protective action.*[37]

This adds problems for both residents and staff in the event of emergency. Thus when unsatisfactory structural design such as:

> *as the existence of a maze of rooms, and limited routes of egress, are added to this equation, the risk to residents is again exacerbated. When unsatisfactory numbers of staff, especially at night, are factored in to this unsatisfactory scenario, the situation becomes the more dangerous. When the absence of a proper local alarm system, and of full sprinklering is added, the likelihood of a tragedy like that before the Coroner now becomes very high and profoundly unacceptable.*[38]

The submission points to the fact it is *'inescapable with congregate care and the low staff-residents ratios'* that a *'diminished capacity on the part of staff'* to deal with the residents and *'dangerous behaviours will not come to attention as quickly as they would in smaller residential units'*.[39] The fire safety nexus with congregate care of the disabled is, to adopt the words of LFF Snowden, really a matter of 'commonsense.'

The Public Advocate asks the rhetorical question whether technological responses can solve the problem and make the residence of a unit like Unit 30/31 sufficiently safe. He submits that the answer is *'a reluctant but emphatic "No"'*.[40] It appears that although DHS's announcement of a *'preparedness to spend significant sums of monies on technologies and training to improve safety'* of residents at KRS is welcomed by the Public Advocate, doubts remain. He says that *'history of such promises and plans is not a happy one, and the history of realisation has exposed many a slip twixt cheque book and implementation'*.[41] It is argued that technologies are far from foolproof; there is potential for human error; that learned helplessness is *'created by the congregate care nature of the units at Kew'*; and there remains a limited capacity to monitor challenging or dangerous behaviours.[42]

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34 Public Advocate's Submission, p. 34.

35 But see an argument in Lloyd, A., *Payment by Results; Kew Cottages' First 100 Years 1887-1987* (First published in 1987 by the Kew Cottages & St. Nicholas Parents' Association), Chapter 10 'Bureaucracy rampant', pp. 45-51. See also a comment by Mr Phillip Adams on the back cover of the book: 'The stigma of intellectual disability must be obliterated and its victims welcomed into our community. There is still a strong case for places like Kew Cottages as alternatives, as options.'

36 Public Advocate's Submission, p. 162.

37 Public Advocate's Submission, p. 162.

38 Public Advocate's Submission, pp. 162-163.

39 Public Advocate's Submission, p. 163.

40 Public Advocate's Submission, p. 163.

41 Public Advocate's Submission, pp. 162-163.

42 Public Advocate's Submission, p. 164.

The Public Advocate's concern is appreciated and noted, but the limits to the Coroner's jurisdiction need to be recognised.

The MFB cautions that, on any move away from 'congregate care', other fire safety problems may be created:

> *The MFB has seen the media reports of the Government's intention to close Unit 7/8 at KRS. There are other reported Government statements about the desirability of caring for such persons within the community rather than in institutions. There is reason to think that this trend will continue. Therefore it is necessary to stress the need for the decentralised residential settings to have adequate fire safety equipment and fire safety systems. There are examples within the community of residential settings that are unsafe in case of fire and though these are not congregate in nature and are quite small scale. While there may well be reasons to move away from congregate care, and any such move may well have some positive fire safety implications, the problem will simply be transferred from one setting to another if the new form of accommodation does not have adequate fire safety equipment (including sprinklers and smoke detectors) and the fire safety system is not appropriate.*[43]

Nevertheless, while many of the issues on congregate care are not within the Coroner's brief, some issues associated with fire and large accommodation units like Units 30/31 may require review. What can be said is that larger accommodation units require well-managed technological and human resource solutions in order to reduce the risk associated with fire. Full sprinklering is obviously part of the solution.

Suffice to say that the State's Reply indicates that both significant resources and risk management strategies are to be directed to the issue of fire safety within DHS's area of responsibility. The commitment is not just limited to KRS but extends to all of the Department's responsibilities and, to a limited extent, into the non-government arena. The extensive and commendable material on fire prevention contained in the State's Reply was presented after delivery of the Public Advocate's and most of the other submissions in the inquest.

9.11 MANAGMENT OF FIRE-LIGHTING BEHAVIOUR OR RISK

The fire and nine deaths at KRS highlight the need for agencies with a responsibility to care for residents who may have disabilities by way of age, infirmity, illness or otherwise to manage the issue of fire-lighting risk or behaviour. In this case, the issue of the potential fire-lighting risk involving a resident was not appropriately investigated or managed. Staff had received no training to enable them to assess risk; the problem, once identified, did not receive the attention that was required.

Where an individual displays fire-lighting behaviour or risk actions, it is vital that the issue be managed. The problem may include not only dealing with the individual but considering smoking policy (which may mean dealing with staff use of cigarettes) or restricting access by residents to fire-lighting implements (perhaps the use of childproof cigarette lighters needs to be considered). The consequences of the failure to manage fire-lighting risk or behaviour are clearly demonstrated by this fire.

There is considerable guidance on this issue contained in the management policies adopted by DHS.[44] Nevertheless, additional specialist advice may be required from agencies such as the Royal Children's Hospital, the MFB and the Country Fire Authority (CFA).

43 MFB Reply, p. 9, para. 27.

44 See Appendix 3.2 of the Findings.

9.12 FIRE AND 'OCCUPATIONAL HEALTH & SAFETY'

At least one member of staff was injured during the evacuation, while others were placed at risk in the aftermath of the fire. Difficulties beset the rescue because of an inadequate fire safety system in a building that has been described as being of *'labyrinthine configuration'*.[45] Poor fire drill and evacuation training cannot have helped.

The management of fire risk and the intellectually disabled has clear consequences for the safety of staff. Staff may be trapped in a fire or injured during rescue attempts, which are sometimes fraught with difficulties because of the disabilities of the residents or the design of the building.

Management at KRS failed to advise staff adequately of the risks, and did not provide the appropriate training or safe systems of work.

9.13 LEARNING FROM THE KRS FIRE: PARTIES' RECOMMENDATIONS

Several parties to the inquest provided the investigation with considered recommendations for systems improvements. The recommendations are detailed in Appendix 3 of the Findings. The State of Victoria and Villamanta Legal Service have reviewed some of those recommendations. These responses are contained in Appendix 4 of the Findings. It is noted that the State agrees with a number of the parties' recommendations.

The importance of the recommendations for improvements in our communities fire safety systems cannot be underestimated. The recommendations vary from issues relevant only to KRS to many applicable to general fire safety. It is essential that each recommendation be carefully considered by agencies with the appropriate expertise.

DHS is involved both in development of the 'model' approach to fire safety across its divisions and in the statewide injury prevention strategy entitled '*Taking Injury Prevention Forward*'. Accordingly, it is considered appropriate that DHS auspice a review of the various recommendations with the following expert agencies – the MFB, the CFA and BSA. Any review process would also need to consider consulting with those involved in the development of recommendations, bodies such as Wormald, ULA, the Health and Community Services Union, the Office of the Public Advocate, Villamanta Legal Service and the Kew Cottages & St. Nicholas Parents Association. Included in that review process would be an overview of the State's 'model' plan.

Where the review process identifies recommendations which may have general application, they may need to be directed to the appropriate agency such as: the Australian Fire Authorities Council, the Building Control Commission, Standards Australia, Australian Fire Protection Association, Institution of Fire Engineers, etc.

RECOMMENDATION 15

That DHS auspice a review of all of the parties' recommendations delivered with the Submissions and Replies. Any review committee should include representatives of the MFB, the CFA and BSA. It also may be useful to include the Building Control Commission and the Victorian WorkCover Authority. Any review of the recommendations may identify areas of:

- ***general or specific application to community fire safety;***

45 Parents' Association Submission, p. 29, para. 81.

- ***application to KRS; or***
- ***application to other areas involving the disabled.***

Where the review process identifies recommendations which may have general application (or application to other areas involving the disabled), they may need to be directed to the appropriate agency such as the Australian Fire Authorities Council, Standards Australia, Australian Fire Protection Association, Institution of Fire Engineers, etc.

Where the review process identifies further potential for improvement in the management of fire safety at KRS, that will no doubt be fed into DHS's model system.

The review would need to consider consulting with Wormald, ULA, the Health and Community Services Union, the Office of the Public Advocate, Villamanta Legal Service and the Kew Cottages & St. Nicholas Parents Association.

9.14 GENERAL ISSUES

Several general issues involving Paul, the fire investigation and commendations to various individuals are considered in this subsection.

9.14.1 FUTURE MANAGEMENT OF PAUL

Counsel for Paul, Mr John Smallwood, indicated some concern about Paul's future management in the event it was found that he lit the fire. Counsel submitted that:

> *[i]f he be formally found to have lit the fire the very real fear is that he will effectively be kept in circumstances where those responsible for his care will be under extreme pressure to avoid a repetition. Because of his extremely limited comprehension of the world around him it would be seen by some that the only effective means of such an avoidance would be the almost total deprivation of his freedom and privacy.*[46]

It is recognised that DHS will, no doubt, ensure that Paul is appropriately managed, balancing his needs under the *Intellectually Disabled Persons' Services Act* 1986 for a degree of freedom and privacy with the issue of safety. However, it is also necessary that the concerns of his counsel be placed on the public record. It is acknowledged that Paul's management plan would need to accommodate competing issues.

By involving independent experts such as Professor Robert Adler, Royal Children's Hospital, in the firelighting issue, DHS is ensuring the adoption of a balanced approach to individuals such as Paul. Improvements in fire safety hardware, sprinkler systems and the management of availability of fire lighters will also help to ensure that an appropriate balance is maintained.

9.14.2 THE INVESTIGATION AND 'FIRE TEST'

Following the fire, an investigation for the Coroner was undertaken jointly by the Victoria Police (Arson Squad), the Fire Investigation Unit of the Metropolitan Fire Brigade and the Victorian Forensic Science Centre. The investigation was run under the protocols developed by the 1995 *'Victorian Joint Fire Investigation Procedures'*.

The MFB, in cooperation with the other investigatory agencies, developed a full 'fire test' that was conducted at leased premises at Scientific Services Laboratory, Port Melbourne. Considerable resources were committed by the MFB to the Port Melbourne 'fire test' with reconstructed, furnished

46 Submission by Counsel for Paul, p. 2.

units and monitoring equipment. In addition, a 'test room' was built to demonstrate the effectiveness of fire retardant bedding, plaster board, smoke alarms and a fast response sprinkler system. A number of the parties were present during the major fire test demonstration at Port Melbourne.

Testing was also conducted at the MFB's 'Fire House', Abbotsford. Prior to the testing, the Brigade undertook computer modeling with the assistance of Dr Mingohun Luo of the Centre for Environmental Safety and Risk Engineering at Victoria University of Technology.

The fire test has been an invaluable tool in assisting the understanding of the many aspects of 'fire' in the residential situation. Computer modelling was used:

> *MFB computer modeling*
>
> *The modeling prediction indicates that installation of an automatic residential sprinkler system would have resulted in sprinkler activation at approximately 190 seconds, prior to the fire spreading from the initially ignited mattress.*
>
> *The graphical results ... (CFAST simulation) ... indicate, in conjunction with the tests and fire scene investigation, that the scenario modelled in this report is feasible in the circumstances which was present at Kew Cottages on the night of the fire.*
>
> *The computer predictions indicate the approximate time of untenable conditions and subsequent incapacitation of the occupants of Flat E in the initial period before total involvement.*[47]

The 'fire tests' in the MFB 'Fire House' at Abbotsford were conducted on 24 and 31 May 1996. The major fire testing, which occurred at SSL's premises at Port Melbourne, took place on 5 July 1996. The MFB Report commented on the fire tests:

> *the fire test*
>
> *... The purpose of the tests was to establish, but was not limited to:*
>
> *Establishing if the tests supported the hypothesis developed from the scene investigation;*
>
> *Validation of the computer modelling being conducted by this department;*
>
> *Assessing the performance of building materials and furnishings similar to those used at Kew;*
>
> *Assessing the performance of residential fire safety systems;*
>
> *Identifying the speed at which a fire will develop in a compartment of similar design to Unit 31 Kew Cottages;*
>
> *Assessing the impact of fuel package proximity in relation to fire spread;*
>
> *Identifying the time taken to reach untenable conditions in such a fire;*
>
> *Assessing the fire resistance of building materials similar to those used at Kew Cottages; and*
>
> *Establishing the speed at which a fire will extend to adjoining compartments.*

It was established that '*although some of the furnishings on their own displayed some form of fire resistance, a composite of materials would produce sufficient heating to cause thermal degradation of components to the stage that total involvement in fire would result*'.

47 MFB Report, p. 207; see generally pp. 107-131 – computer modelling.

One test assessed the performance of fire-related lining material for building interiors, and it was commented:

> *This test involved a fuel package consisting of a bed and bedding being set alight and allowed to burn unchecked within a compartment lined with 1 hour fire rated plaster board. Once the fuel package had been completely consumed by fire, an inspection of the test cell revealed that the cell was intact, its integrity had not been affected and there had been no fire extension beyond that compartment.*

Another test within the same test cell demonstrated the effectiveness of a residential sprinkler system. The sprinkler head *'operated at 230 seconds and extinguished the fire within a further 3 seconds. An inspection of the cell revealed that only a small portion of the fuel package had been consumed. The sprinkler head had extinguished the fire well in advance of untenable conditions having been reached'*.

The final test was conducted in a purpose-built structure, built to similar specifications to that of the two northern bedrooms and hallway of Flat E, Building 37, KRS. In that cell:

> *[t]he fire was set and allowed to burn unchecked until building collapse had occurred some 24 minutes after ignition. During the tests, temperature readings were taken at varying levels within each of the compartments. In addition to the temperature readings, oxygen depletion, carbon monoxide production as well as the lower explosive limits of all gas species were recorded.*
>
> *The tests concluded that smoke alarm operation within bedroom 1 (the room of fire origin) occurred in 38 seconds with the detector in bedroom 2 occurring in 156 seconds.*
>
> *Three minutes after ignition, the oxygen and carbon monoxide levels were becoming dangerously low which would have affected the safe evacuation of any occupants.*
>
> *The tests concluded that the bedding materials could be ignited by way of a cigarette lighter flame and although the fire took some time to develop, sufficient heat could be generated to cause decomposition of the Medishield mattress cover allowing the polyurethane foam mattress to become involved. Once this occurred, the development of fire was rapid.*

The manner in which the test unfolded supported the theories held by the investigation team relative to the cause and origin of the fire at KRS. The test also confirmed that a composite of building materials similar to those used to ensure the security of residents, such as medium density fibre board, polycarbonate glazing, security shutters and window limiters, presented a significant fire risk.

The MFB Report, developed with the aid of the fire test, cautions that:

> *[t]he tests displayed the development of a fire within a compartment, not protected by sprinkler coverage. This is of significance given the case of a partially sprinklered premises. In the case of a partially sprinklered premises, a fire could develop within a compartment to the extent that, when it spreads to an adjoining compartment that is sprinkler protected, it may well overrun the supply of water to the sprinkler. In other instances, collapse of the structure may occur thus rendering the sprinkler system inoperable.*[48]

Finally, the MFB Submission suggests that:

> *[t]he members of the FIU of the MFB involved in this inquest have devoted themselves to a comprehensive investigation of the fire since it occurred and to providing as much*

48 MFB Report, p. 206; see generally MFB Report, pp. 42-106 – fire tests.

assistance as possible to the Coroner. Inspector Martin has been present throughout the inquest to provide advice and assistance to the Coroner and the parties as necessary. Various aspects of the work of the FIU have been of particular use to the Coroner and the parties, most importantly the test burns which have underpinned much of the analysis about both cause and origin of the fire and deaths, and the recommendations that might be made. These members of the FIU all deserve commendation for their work.[49]

This is agreed. The professional level of the work undertaken by the MFB, Inspector Martin and the officers at the Fire Investigation Unit to assist the inquest is highly commendable. Throughout the inquest the MFB provided an objective and valuable level of assistance to the Coroner.

9.14.3 COMMENDATIONS

PUBLIC SAFETY

The MFB Submission remarks on the great risks and demands placed upon both MFB officers and KRS staff when evacuating the clients. Appropriately, it commends *'the KRS staff who were engaged in the evacuation effort for the contribution they made in uniquely challenging circumstances. The efforts of Mr Frlan in particular deserve special commendation. The result was that all disabled clients from Flats A, B, C and D and one survivor from Flat E (a total of 36 persons) self-evacuated or were evacuated safely from Unit 30/31'*.[50]

The court joins with the MFB Submission on this issue. All the fire officers involved in the incident and evacuation effort are deserving of commendation for their work. On any view, Mr Calder's action is deserving of special commendation. Mr Morris' actions are also commendable. It is considered that KRS staff member, Mr Chea Earpeng, should be added to the list.

9.15 CONCLUSION

Fire safety systems must be considered as a total package of risk management, equipment, maintenance, training and fire and evacuation drills. Once systems are established, audit must be regular and rigorous. Where disabled or immobile persons are concerned, the importance of the total package cannot be underestimated. Early warning to residents, staff and firefighting agencies in the event of the first signs of fire is vital to maximise the potential to reduce the risk of injury and death. Well-developed evacuation procedures are vital. Modern, fast-response residential sprinkler systems designed to reduce fire spread are essential. Building design layout, taking into account fire risk and potential spread, is an important consideration. Where locked doors restrict residents, it is vital for efficient and safe evacuation that automatic door latch release mechanisms be included in overall layout.

In conclusion, it is essential that the lessons of this fire are addressed by our community and also by those charged with the responsibility of caring for the disabled.

Graeme Johnstone
State Coroner
17 October 1997

Assisted by Messrs Graeme Hicks and Michael Hennessy (instructed by Ms. Vanessa Ash of the Office of the Director of Public Prosecutions)

49 MFB Submission, p. 51, para. 114.

50 MFB Submission, p. 39, para. 91.

APPENDICES

APPENDIX 1 SUMMARY OF FINDINGS, COMMENTS AND RECOMMENDATIONS

INTRODUCTION

This Summary has been prepared as a summary of, and guide to assist in understanding, the information in the Findings, Comments and Recommendations. As it is a guide only, where there is any conflict between it and the Findings, Comments and Recommendations, the latter prevails. There are several issues dealt with in the Findings (or the Comments and Recommendations) that are not considered in detail in this Summary or at all.

KEW RESIDENTIAL SERVICES (KRS)

The facilities at Kew Residential Services (KRS) are operated by the Department of Human Services, Victoria (DHS). The departmental names of DHS's predecessors include the Health Department and the Department of Community Services.

The institution formerly known as 'Kew Cottages' is situated on about 40 hectares of parkland in the Melbourne suburb of Kew, and contains 28 residential units. KRS provides accommodation for approximately 600 intellectually disabled residents ranging in age from 21 to 68. It is a residential facility, not a hospital, designed as far as practicable to provide a home-like atmosphere. The residents are encouraged to take part in hobbies and may be permitted to consume alcohol or smoke cigarettes. The smoking policy provides for an informed choice by a resident. However, smoking is not permitted in accommodation units.

The policy designed to encourage residents to partake of as normal a life as possible began with the commencement of the *Intellectually Disabled Persons' Services Act* 1986. Under that legislation, principles were enunciated whereby the services to be provided to people with intellectual disabilities were to emphasise their rights to lead as normal a life as possible.[1]

PART 1 THE FIRE, ITS AFTERMATH AND CAUSE

1.1 THE DEATHS

The deaths of Alan Negri, Joseph Richmond, Adrian Edmunds, Thomas Patrick Grant, Shayne Newman, Bruce Mark Haw, Stanley Mathews, Peter Arthur Bernard Otis and Ronald Aldridge all occurred in the evening of Monday, 8 April 1996 at KRS, Princes Street, Kew, from smoke inhalation and burns.

1. 2 SUMMARY OF THE CIRCUMSTANCES OF THE FIRE

At about 10.49 p.m. on 8 April 1996, a fire commenced in bedroom 1, Flat E, Unit 31, Building 37, 6 Lower Drive, KRS. Building 37 was made up of two units – 30 and 31. Unit 30 housed Flats A and B. Unit 31 comprised Flats C, D and E.

The alarm of the fire rang at the Metropolitan Fire Brigade (MFB) Communication Centre at about 10.56 p.m. The first MFB pumper arrived at KRS approximately five minutes later. By the time the pumper arrived, the fire had broken through the roof above Flat E. It had also begun to spread through the roof space to the adjoining Unit 30

1 See generally State of Victoria Submission in Reply, pp. 1-6; Public Advocate's Submission, pp. 166-174.

when it was checked by a number of firefighters. The fire had rapidly developed to engulf all of Flat E, Unit 31, and parts of Flats B, C and D were damaged. The remainder of the building received some smoke damage.

After the alarm was raised, a number of staff at KRS began a difficult and traumatic evacuation of the surviving residents. They were assisted by a number of firefighters who arrived within minutes. The firefighters succeeded in rescuing at least two residents who had remained in their smoke-logged bedrooms in another part of the building. In total 35 residents survived. They were evacuated by staff and Fire Brigade Officers.

Two residents (of Flat C) and one staff member were injured during the fire. All received hospital treatment.

The fire was started by the sole surviving resident of Flat E with a cigarette lighter. The seat of the fire was his bed in bedroom 1, Flat E. The resident did not understand the consequences of his actions. He was known to collect items and had a recorded history indicating that he was a fire-lighting risk. Not all staff were aware of this history.

During the day the resident was observed to be playing with a cigarette lighter, which was removed by staff. Unfortunately, the resident managed to regain possession of the lighter. This lighter was later discovered to be inoperable. However, the resident used another lighter to light the fire.

A sprinkler system was in the process of being installed to Units 30/31. However, at the time of the fire, it was not operational. A new addressable alarm system was also about to be installed.

There were a number of difficulties experienced during the evacuation. These difficulties stemmed from inadequate training and support but, despite the difficulties, all KRS staff performed their tasks to the best of their ability given their level of training and support. The MFB firefighters involved in the emergency performed their tasks in a professional manner. For both KRS staff and the MFB, it was a highly stressful and difficult situation.

The evidence also establishes that the MFB promptly responded to the alarm call arriving five minutes 37 seconds after the call. The response of other units thereafter was equally efficient. The fast response of the MFB to the alarm of fire obviously saved lives.

PART 2 KNOWLEDGE OF RISK AND SYSTEM DEFICIENCIES

Numerous fire brigade reports have demonstrated the deficiencies in the fire safety system at KRS since the late 1980s. An MFB fire audit prepared in 1986 commented that the MFB's purpose *'is to provide an acceptable level of fire protection and safety'* and that it was *'mindful of the fact that the majority of the buildings have been built for a considerable number of years and fire safety standards have not been maintained in accordance with current regulations'*.[2]

The MFB also documented the number of fires at KRS (and Willsmere Mental Hospital) during the period 1963 to 1996 as at 72. In addition, the MFB reported the false alarm rate at KRS for the period 1983 to 1996 as at 634 calls. The MFB argued that *'a high incidence of false alarming undermines user confidence in the system'*. It pointed to the fact that *'[m]any of the staff involved in the rescue on the night of the fire thought that the alarm of the fire was yet another false alarm'*.[3]

The number of fires at KRS in the eleven years to April 1996 was 65. Although these figures must be treated with caution (as a reported fire may result from 'burning toast'), there are sufficient incidents to be of concern.

From 1992 there are a number of consultants' reports on fire safety at KRS. These are the Lumley Report, the Dibben Report, the Umow Lai (ULA) Report and the Fabric Survey. The ULA Report was presented to KRS in August 1994, and culminated in the moves to upgrade the fire safety system by introducing an 'addressable detector' alarm system and partial residential sprinklering throughout the residential section of the complex. At the time of the fire, the new system was only partially installed and not operational. ULA made several additional recommendations which were not followed.

The Lumley Report raised a number of concerns about the fire safety system at KRS, which included documentation, emergency evacuation drills, exits etc. In summary, the report commented that there were *'several of the risk exposures'*, which were either *'similar in a number of occupancies, or, presented a potential for major loss, or, can be applied universally within similar centres'*. The report's recommendations were designed to *'support several commendable initiatives already introduced'* at KRS.

2 Exhibit 171 – 'Dobson', p. 2 (63 pages).

3 MFB Submission, p. 106, para. 187.

In 1993, the Dibben Report dealt with a wide range of fire safety deficiencies at KRS. In a telling comment, Dibben warned that '*[t]he greatest exposure of the Department to an emergency is during the after hour periods where 40 direct care staff only are on duty'*. Under the heading 'Evacuation and Emergency Procedures', Dibben remarked that if:

> *a fire occurs out of hours, the high probability of rapid fire extension in most buildings will cause a grave situation. This will be exacerbated by the low staff levels and time and space (distance people need to travel to the scene).*[4]

The Dibben Report considered that the first priority of the work is '*for the focus on the existing emergency management infrastructure to be expanded and upgraded to include establishment of a formal emergency management structure, revision and re-presentation of the existing emergency manuals'*. The report also considered that physical works are necessary in order to *'minimise the client life risk in an emergency environment'*. Significantly, the report regards the works as a *'package which will collectively provide an environment where client life safety and Departmental exposure are minimised'*.

The Dibben Report recommended the revision and upgrade of the early detection service as it '*is aged, has detectors which are inappropriate and is linked to two separate fire indicator panels'*. Emergency lighting should be installed in units where lighting is not already installed, which would facilitate evacuation during an emergency when there is a power failure. The report also suggested replacement of the fire and domestic water supply as the existing service is *'old, prone to failure and beyond reasonable repair'*. The installation of residential sprinklers which can *'provide almost 100% guarantee for client safety in addition to building fabric preservation'* was also recommended. Furthermore, the report detailed staffing issues and commented on resident mobility, and suggested a pragmatic approach to people safety (but to conform to the Building Code of Australia (BCA) objectives at most times). It recommended that a *'door lock strike system ... be installed to the same specifications as other institutions'*.

Further, the Dibben Report recommended the installation of 'mimic' fire alarm panels in all units so that staff could receive early warning of fire. In addition, it recommended the replacement of thermal detectors with smoke detectors in accordance with the BCA and Australian Standards. Specifically, on the detection system, it is said that it has *'grown like topsy, with no plans, no integration, no central control or communication system using old and new technology'*. It pointed to the mixture of part thermal part smoke detection systems *'connected by old technology wiring* [which] *is cause for concern. There is no doubt that this is a contributing factor to the high incidence of false alarms. Good maintenance would assist to minimise such occurrences'*.

The Dibben Report was considered by a branch of DHS (CMB) to be being 'technically flawed', and thus was not shown either to KRS or, later, to ULA when preparing its report. Nonetheless, the Dibben document is significant because it took a 'holistic' approach to the management of fire risk at KRS. Mr Norm Winn, a fire safety expert, was one of the authors of the Dibben Report. In preparing the report, Winn received *'excellent cooperation and support'* from Messrs Taylor, Vasan and supervisory staff at KRS. On Mr Vasan's involvement, he commented that:

> *I particularly found Srini Vasan to appreciate that there were deficiencies in the quality of procedures and some equipment and documentation, and found him anxious that improvements be made at Kew. Srini Vasan specifically expressed his concerns about staffing levels at night and that this together with their lack of training would provide difficulty in effecting evacuation of residents in an emergency.*[5]

The 1994 ULA Report, although dealing in part with many of the management issues covered by Dibben, focused on an 'engineering' solution. When read together, the Dibben and ULA reports show that many of the issues raised in the Lumley Report had not been properly addressed. For example, Dibben recommended that the maintenance program for the fire alarm system at KRS be audited. This was not done. In 1994, ULA recommended that the Fire Safety Committee be reconvened, and suggested that this committee consider maintenance of the alarm system as part of its brief. The committee was not re-established, and thus maintenance was not reviewed.

The concerns of the ULA Report are clear:

> *Based on the fire risk assessment, a fire in a residential unit could develop to a point where untenable conditions exist prior to full evacuation of the affected area.*

In the introduction to its report, ULA remarked that the Board of Management at KRS '*recognised that the present fire and life safety provision may not be of sufficient standard to provide a safe environment for the clients who live at or people who work at the Centre every day in the event of a fire occurring'*. Under 'Fire Safety Systems', the report commented on the detector issue that:

4 Exhibit 54 – Dibben Report, p. 6.

5 Exhibit 299 – Mr Winn's statement, para. 11.

> *[l]imited fire detection is provided. In many units there is a mix of heat and smoke detectors, with quite substantial number of areas having no detection at all. Where detectors are installed, many are old, discoloured and in need of replacement.*

On alarms, the report commented that:

> *[a] number of buildings have individual fire indicator panels that provide local alarms. However many buildings have no local alarms and must rely on telephone calls for alarm signalling from the administration building.*

A 'Fire Safety Audit' was conducted for ULA by Scientific Services Laboratory (SSL), which identified a significant number of problems.[6] ULA commented on the fact that regular fire drills were no longer performed and that some staff had no training. The report also made the point that reducing numbers of staff lowered the probability of satisfactory staff response to an emergency.

During the inquest, it was determined that the ULA Report did not adequately deal with a number of issues. It failed to draw sufficient or any attention to:

(1) the maintenance of the detector system or circuitry;

(2) the absence of circuit and detector plans;

(3) the locked doors; and

(4) fire-lighting behaviour.

In addition to the ULA Report, there was a *'Fabric Survey & Building Utilisation Study: Part A Kew Cottages'*, which was completed in September 1994 by Group 4 Design Pty Ltd. It was prepared for 'Health and Community Services, Victoria – CMB and Disability Services Branch (DSB)'. The 'Client Project Team' included representatives from DSB, 'The Management & Staff Kew Cottages' and CMB. This is yet another document presenting warnings and solutions on fire safety to the State of Victoria.

A review of all of the fire brigade and consultants' reports renders it abundantly clear that ULA was not the only repository of advice and knowledge on the inadequacies of the fire safety system.

Over the years, there have also been several coroners' inquests and recommendations dealing with fire and safety for the elderly, infirm and disabled. They draw attention to deficiencies in fire safety systems where the disabled are housed. Issues such as smoke alarms, sprinkler systems, fire audits, managing of fire-lighting behaviour and evacuation procedures have been dealt with by coroners since the early 1990s. Details of the findings and recommendations are covered in Part 2.

There was a strikingly similar fire in 1968 at Willsmere Mental Hospital (on the KRS site) which resulted in six deaths. Recommendations about sprinkler systems were made by the fire brigade during the inquest into the 1968 fire.

Concerns were also expressed by the Community Visitors and by the Kew Cottages & St. Nicholas Parents' Association.

From the early 1990s, the Victorian Government issued directives which applied to the public sector and dealt with significant reforms of building law. These directives are aimed at improving safety levels in government buildings. Also government agencies issued directives requiring the installation of smoke detectors.

It is also noted that Mr Taylor, Facilities and Services Manager, KRS, was given responsibility to implement major fire upgrade works recommended by the MFB in 1988. He wrote, with some frustration, to the Ministry of Housing and Construction, on 7 August 1989:

> *You should be aware that over 750 intellectually disabled people are accommodated at this Centre. Many of these people have profound physical and intellectual disabilities and would be placed at enormous risk in the event of a fire.*

---

6 Including (but not an exhaustive list): higher fire loads in the sleeping areas, particularly high combustible mattresses, bedspreads, clothing baskets, cupboards etc in many buildings; limited cigarette smoking in some buildings and radiators/ toasters but only in staffed areas; no automatic sprinklers; heat and some smoke detectors but many areas without detectors; exit and emergency signs not consistent and in some areas not provided at all; only a limited number of buildings with fire indicator panels and local audible alarms; regular fire drills no longer performed and some staff have no training; reduced numbers of staff lowers the probability of satisfactory staff response to an emergency; no earth leakages protection on electrical power circuits: see generally the ULA Report, pp. 6-7.

The management of Kew is not prepared to tolerate any further procrastination on this project. As we have consistently informed the Ministry funding is immediately available to commence installation on a rolling budget basis. Alternatively, and if required, funding for total installation would be pursued through appropriate funding sources.[7]

Thus it is clear that the State of Victoria was on notice from KRS management of the risk to residents at KRS. The number and type of fires during the eleven years prior to 1986 should have put management on notice as to the likelihood of fire at the complex.

Over ten years of warnings have been given to various governments and their agencies with a responsibility to care for intellectually disabled clients at KRS. Indeed the potential for a tragedy of this magnitude was foreshadowed by the Willsmere fire on the same site in 1968, with the deaths of six residents of the Mental Hospital. On that occasion the MFB called for the introduction of sprinkler systems. In spite of these warnings, by the time of the fire, the recommended fire hardware safety systems had not been completed. Nevertheless, there was considerable progress towards hardware solutions in the form of a new addressable alarm and partial sprinklering. Recommended management systems aimed at fire safety had not been adopted; these included the re-establishment of the Fire Safety Committee and improvements in fire drills, evacuation procedures and auditing of maintenance.

The totality of the warnings form the basis of a determination of contribution to the deaths by the State of Victoria, which owed a duty to residents under its care to protect them by providing an efficient, safe and proper fire safety system.

PART 3 MANAGEMENT OF RISK AND SYSTEM DEFICIENCIES

There are a number of key issues that bear upon failure to manage the risk of fire at KRS. Principally, these issues range from funding delays, asbestos, the Fire Safety Committee (and management of evacuation procedures), maintenance and audit to the management of fire-lighting risk.

DELAYS IN MOVES TOWARDS AN UPGRADE

From the late 1980s, Messrs Taylor and, later, Srini Vasan worked towards upgrading the fire safety systems at KRS. Taylor was the Facilities and Services Manager, while Vasan, who was a marine engineer by qualification, was the Maintenance Manager.

In about April 1990, as a result of correspondence between Mr Taylor and the Ministry of Housing and Construction, the Department of Management and Budget agreed to allocate $600 000 (over a two-year period) for an upgrade of the system. During the same period, a further amount of $750 000 was made available for the upgrade of the fire ring main. In spite of the allocation, it was not used in 1990.

Following the Lumley Report, work continued towards an upgrade with improvements in the system being categorised as either urgent or critical. In early 1993, Mr Taylor allocated about $50 000 from the annual maintenance budget to install hard-wired smoke detectors. This decision resulted from a *'Departmental state wide directive that smoke detectors should be installed in such premises'*.[8] As a result, some 285 hard-wired smoke detectors were installed, being connected to the existing thermal system, fire indicator panels and the MFB.[9]

In late 1993, Mr Taylor *'first learned that the Capital Management Branch of the Department would manage the fire prevention upgrade'*.[10] Mr Savona of CMB directed that a Project Control Group (PCG) be formed for the tendering process for the audit and implementation. Evidently, Capital Management required that *'there be a comprehensive fire prevention audit to provide the basis upon which the fire safety system would be improved'*.[11] After delivery of the Dibben Report to CMB in early 1994, tenders were called for a fire audit. During the interview process of five companies that were short-listed, questions were asked about 'Interim' solutions. ULA was commissioned as the consultant for the audit and Principal Consultant for the upgrade. Upgrade work commenced in October 1995 with Wormald being granted the contract.

From the early 1990s to the upgrade, there were delays. The State of Victoria in its Reply admitted:

7 Exhibit 234 'JT12'.

8 Exhibit 176, para. 7; see also Exhibit 159, p. 6.

9 Exhibit 159, p. 6.

10 Exhibit 159, p. 6.

11 Exhibit 159, p. 7.

The delay in the obtaining of a fund allocation from the time Mr Taylor first submitted the upgrade as a priority capital works project should be a matter of justifiable concern. The State of Victoria accepts much of the criticism that has been raised by various parties concerning this delay. The functioning of government and the bureaucratic process accounts for much of this delay. The State of Victoria recognises that the constructive criticism that has been raised will lead to the reform of some of these processes.[12]

Before upgrade work commenced, asbestos was discovered at KRS. Despite clearance certificates, further asbestos was discovered in the roof of Building 37, Unit 31. Once asbestos was discovered in the roof, work ceased until the issue was resolved. By the time of the fire, it had not been finally resolved in the Unit 31 area.

MAINTENANCE, AUSTRALIAN STANDARDS AND AUDIT

The annual maintenance of KRS's fire alarms was undertaken by a contractor engaged by the Victorian Government 'Building Services Agency' (BSA), which acted as agent for DHS. Annually, tenders were invited for the maintenance contract, and Jonkar Industries Pty Ltd were the successful tenderer as from 1991. Jonkar Industries is a small fire protection service firm registered with the MFB and the Country Fire Authority (CFA) as an installer and maintainer of fire alarm systems. At the time of the fire, it operated with two partners and three service personnel. The business was operated from the partners' home in Box Hill.

Each yearly maintenance agreement was to be carried out in accordance with a specification that the work was to be executed in accordance with Australian Standards – AS 1670-83 and AS 1851-86. The work was to be carried out by competent tradespeople *'to the accepted trade practices and to the satisfaction of the Public Works'*. Also it was said to be *'to the satisfaction of the Superintending Officer'*.[13] Unfortunately, there was no checking of Jonkar's maintenance work by BSA. As a result, the many deficiencies in the maintenance remained undiscovered until the inquest. Evidently, 'technical audits' of maintenance work are not normal industry or government practice. A number of consultants' reports commented on maintenance. In particular, the Dibben Report recommended that maintenance procedures be checked.

During the inquest, it was discovered that Jonkar failed to follow Australian Standards in several areas while maintaining the fire alarm system at KRS. Obviously, Jonkar did not install the system; it came in at a late stage to manage the maintenance. Persuasively, Jonkar submitted that *'the overwhelming evidence produced at the inquest was that the fire detection system was antiquated and, in many respects, inadequate'*.[14] This fact was no doubt obvious to all involved in the inquest and had resulted in the work to upgrade the system. It was argued that Jonkar maintained the system on a limited budget so that it was a properly functioning system.

However, considering the number of deficiencies in the maintenance procedures adopted by Jonkar, the system was further compromised. The State of Victoria listed the following areas where the Jonkar breached its duties and compromised the system:

(1) Incorrectly placing detectors and/or failing to rectify the incorrect placement of detectors;

(2) Failing to perform a thorough visual inspection of detectors for factors that could adversely affect their functioning;

(3) Installing and/or failing to rectify the installation of an excessive number of detectors on Circuit 39;

(4) Failing to ascertain the status and verify the integrity of wiring in Unit 30/31[and] *failing to inform BSA or KRS of any potential deficiencies as a result of faulty or aged wiring.*

(5) Keeping poor records and inadequate plans,

(6) Insufficient training, instruction and supervision of Jonkar Staff.[15]

The above deficiencies in Jonkar's maintenance regime are supported by the evidence.

FIRE-LIGHTING RISK

In 1994, one of the residents in Unit 31 – Paul – was listed as having 'fire-lighting behaviour'. This was recorded in his file, but many staff had not read this information. The recording of Paul's potential responses with fire as 'fire-lighting behaviour' is incorrect as it should have been described as 'fire-lighting risk'. Paul did not understand his actions, although he had the ability to operate a cigarette lighter. Thus he was a risk if he had access to fire-lighting implements such as cigarette lighters.

12 State of Victoria Submission in Reply, pp. 261-262, para. 83.

13 Exhibit 176 'SV2'– Mr Vasan's statement.

14 Jonkar Submission, p. 6, para. A6.

15 State of Victoria Submission, p. 230, para. 1.215.

The MFB Submission essentially argues that there was a failure to manage Paul properly. It makes the following points:

- All disabled persons with the necessary motor skills to light a fire are a potential fire risk because of their inability to understand the consequences of their action.
- There was a body of written evidence and oral history showing that Paul was a significant risk in terms of fire risk behaviour or fire-lighting behaviour.
- Paul hoarded objects and kept them secretly in his room. He was previously observed to be playing with fire lighters as he did on the day of the fire.[16]

Although the MFB's Submission does not properly describe Paul's potential actions as 'fire-lighting risk', the central issue in this fire incident is the effective and practical management of the risk. The reasoning behind this theme can be seen in the Public Advocate' Submission to the effect that:

> *[a] key element of the minimisation of the risk of fire is the effective and sophisticated management by carers of persons who might have the propensity to cause risk. As would be true of any proportion of the population, the grouping together of a large number of people will include individuals who display behaviours that may cause risks. Such behaviours may pose a threat to others in the group, some may pose a threat only to the individual himself or herself. The evidence establishes that many residents at Kew Residential Services displayed challenging behaviours.*[17]

In 1995, following an inquest into two deaths by fire, recommendations were made to DHS on the issue of managing fire-lighting behaviour. The fire was caused by the fire-lighting behaviour of an 11-year-old autistic child. His parents regularly sought assistance from Health & Community Services in managing his behaviour. The child set fire to his home in which both he and his mother died.[18] The department also advised its staff:

> *Fire Risk Behaviour*
> *Staff must take particular care where a client or family/carer is involved with dangerous behaviour with fire. Staff must discuss with the client/family/carers all reasonable precautions, including the use of smoke detectors, whether or not the client is living in their own accommodation.*
>
> *Where a young person is involved in risky behaviour with fire, staff should also consider a referral to the Metropolitan Fire Brigades' Juvenile Fire Awareness and Intervention Program or similar program offered by the Royal Children's Hospital.*[19]

Paul was regularly searched as he had a tendency to collect items; however, there was no real plan to manage any fire-lighting risk. Deficiencies in the management of fire-lighting risk were acknowledged by the State of Victoria during the inquest. For example, DHS admitted:

> *Assessment and Management of Clients with Fire Lighting Risk*
>
> *The Department of Human Services acknowledges that at the time of the fire the approach to assessing and managing clients who were a fire lighting risk was not as comprehensive or as expansive as required nor was the approach incorporated into the department's systems.*
>
> *In responding to the recommendations of the inquest into the death of Moc Qui Tran the Department's approach was confined to clients who had a known propensity for fire lighting. In following this approach the assessment of clients was limited in scope. While the department generally alerted staff to the need to identify clients with behaviour which may pose a risk it did not adequately systemically embed this approach into some of the main practices and procedures of the department.*
>
> *Since 1996 the approach taken by the department has been broadened. The approach has addressed the issue on two levels. First the assessment process has now been expanded to include clients who have a known propensity to light fires and now includes clients who are a fire lighting risk due to their reduced cognitive functioning and limited physical independence skills.*

STAFFING LEVELS FOR FIRE EMERGENCIES

On the night of the fire, there were two staff on duty in Building 37. Despite warnings from consultants of the risks of fire at night, increasing staffing levels in the building as an interim solution was apparently not considered. The proposed fire safety upgrade which was nearing completion on the night of the fire would probably have saved the

16 MFB Submission, p. 77, para. 153.

17 Public Advocate's Submission, p. 84.

18 Moc-Qui Tran Inquest.

19 Exhibit 270 in documents with 'End of Financial Year Report'. See also references in the Moc Qui Tran Inquest.

lives of the nine residents. With its engineering solutions, it would have substantially addressed the staffing level issue too. However, in spite of the warnings by the Lumley, Dibben and ULA reports on the problems associated with low staffing levels at night, the issue was not addressed in the interim. The residents were accommodated in temporary accommodation during the renovations and were moved back into Unit 31 on 5 November 1995.[20]

Reliance and focus were placed on completion of the upgrade rather than on appropriate assessment of the staffing levels for the existing and, in particular, the newly renovated Building 37 (Unit 31). Tracing the warnings of the Lumley, Dibben and ULA reports, there appears to be a clear message on this issue, which needed to be addressed while the upgrade was being completed. It was not. Management was not deprived of the ability to act because of any failing of ULA but by its own failure to take advice.

INTERIM SOLUTIONS

From the outset, both DHS and KRS identified the need for interim hardware solutions well prior to the fire and the hiring of ULA as consultants. At the interview to select the consultants, DHS specified low cost and integratable interim hardware systems from ULA, which was of the view that any such system would not be low cost or integratable with the final system. Further, it did not identify any interim hardware systems that had been approved by the relevant authority. Accordingly, it was decided not to install any interim hardware solutions and to concentrate on the upgrade. Once it was decided not to proceed with interim hardware solutions, management did not consider other interim solutions recommended in the various reports.

Despite clear warnings of the risk, DHS/KRS did not provide adequate interim fire safety measures or management solutions (pending upgrade) to protect residents on the night of the fire. There was an identified failure to draw together the many reports and recommendations dealing with the KRS fire issue. Sound management would dictate a process of review of the many reports and recommendations to globally consider whether or not the problems have been addressed.

In 1995, KRS substantially altered Unit 31 to create a number of flats. That renovation created additional difficulties for supervision and evacuation in the event of fire. During the renovation the residents were moved out into temporary accommodation.

CONCLUSION: A RESPONSIBILITY TO MANAGE RISK

The responsibility of management on this issue is clear. There was a failure to manage the risk.

The failure to draw together the many reports and recommendations on fire safety at KRS is a factor. It meant, for example, that the additional recommendations in the ULA Report did not receive the required level of attention. There was a failure to make the very necessary links between recommendations and significant inaction in a number of areas of fire safety by management at KRS. Guide posts to 'interim solutions' were suggested in many of the recommendations of the various reports over the years. These reports were not considered on a global basis by management to deal with the number of similar recommendations in each report.

Whether the provision of interim hardware solutions throughout the complex prior to completion of the upgrade would have altered the outcome is a moot point. As suggested by counsel for SSL in one of his less strongly worded submissions:

> *There is just no evidence that any "interim" measure amounted to a "solution" which would have prevented the fire occurring or have led to lives being saved. Even if there were, that would not lead to the comfortable satisfaction that SSL breached a duty of care owed to those at Kew which was a cause of the fire or death by the provision of unreasonable advice or the unreasonable failure to advise. The most that can be said is that the world class experts did not and still do not believe that there was any suitable interim solution per se.*[21]

Obviously, the interim hardware solutions being discussed by the engineers would not have had an effect on the commencement of the fire. Any interim hardware solutions would have been directed towards early warning and thus to rescue and fire reduction. It is also necessary to remember that the initial discussion on interim solutions took place well before KRS renovated Unit 31. The interim solutions having the potential to check the commencement of fire were: managing of fire-lighting risk and adequate supervisory staff in light of the identified inadequacy of the fire safety system. It is necessary to remember that increasing staffing for fire emergency would have been limited to the interim period during the upgrade.

One interim solution apparently not considered was the issue of moving the residents back into residence after the renovations and before the final upgrade.

20 Transcript, p. 6857 (Ms. McCartin).

21 SSL Submission, p. 28.

PART 4 SURVIVAL AND THE DETECTION SYSTEM ON 8 APRIL 1996

Since the fire, there has been considerable difficulty in ascertaining the state of the fire alarm system on the night. The alarm system operated at its limits at about seven minutes 45 seconds after the fire started in the bedroom of fire origin. It was probably a thermal detector that gave the alarm. This gave no chance for the residents to be rescued.

STATE OF THE SYSTEM ON 8 APRIL 1996

An understanding of the state of the system is assisted by viewing the plans and diagrams in Appendix 2 to the Findings.

The system that was meant to be in place comprised smoke detectors in all the bedrooms (including the room of fire origin) which, if operating correctly, would have given the alarm within about 45 seconds. Because of fire damage, a lack of adequate plans and the number of contractors involved in maintenance and upgrade, there have been difficulties in precisely identifying the existing system and its operational state. After the fire the MFB and two expert consultants have examined the material and the scene to assist in determining fire cause, sequence and the state of the alarm system.

There are a number of theories as to the state of the system and the cause of its failure. They range from resident damage, interference by the new system's installers (Wormald) to replacement of all smoke detectors with thermals in the bedrooms of Flat E by the maintenance contractor – Jonkar. Briefly, the theories are as follows:

- potential for inadequate maintenance (by Jonkar)
- interference during fire alert system installation (by Wormald and/or its subcontractors)
- interference during sprinkler system installation (by Wormald)
- interference during airconditioning installation
- damage to detectors (residents' actions/painting by KRS contractors)
- integrity of existing system (positioning, number of detectors on circuits, wiring etc)
- replacement of smoke detectors with thermals (by Jonkar).

An examination of the evidence indicates that it is unlikely that Wormald's work in Unit 31 caused the system to fail.

Jonkar had adopted the practice of temporarily replacing smoke detectors with thermal detectors when false alarm problems developed. This usually occurred during renovations. Although Jonkar's employees gave evidence that after the renovations were completed smoke detectors were replaced, there is no confidence that this occurred. Because of this practice, it is considered likely that the smoke detectors in the bedrooms of Flat E had all been replaced by thermals by the time of the fire. However, there are some areas of doubt, which are emphasised by the fact that one of the experts – Warrington Fire Research – comments that there was every potential, in view of problems with both system design and maintenance, for alarms to fail. For example, many issues remained to be corrected:

- *provision of numerous joints in cabling with plastic connections or in one case, twisted wiring;*
- *too many detectors on one circuit;*
- *detectors close to supply air inlets and lights;*
- *damaged/overpainted detectors.*[22]

All added to the potential for failure of the system. The Warrington Report considers that the probability of failure of smoke detectors raises concern about system reliability:

> *Since a number of non-compliances with the design code were identified in Units 30 and 31, it is considered that the system would have a below average reliability and therefore there was a significant probability for failure of the detection system in place at the time of the fire.*[23]

22 Exhibit 201, p. 17.

23 Exhibit 201, p. 17.

Management at KRS were aware of Jonkar's practice of changing smoke detectors with thermals. For example, Mr Taylor had a continuing *'lack of faith in the ageing system'* and, when questioned at the inquest, stated:

> *Mr Osborn: But you didn't ask Mr Stewart to investigate whether the causes of the false alarms could be attributed to particular problems with the equipment or its maintenance?*
>
> *Answer: No, I never did, no.*
>
> *Question: Did you know that Jonkar's had replaced some smoke detectors with thermal detectors?*
>
> *Answer: Yes.*
>
> *Question: Was that something that you discussed with Mr Stewart?*
>
> *Answer: No, we didn't.*
>
> *Question: Or with anyone who had expertise in fire protection?*
>
> *Answer: No.*[24]

POTENTIAL TO SURVIVE WITH A CORRECTLY OPERATING SYSTEM

Despite problems with the evacuation on the night, it is likely that the residents would have survived with a properly operating system. An examination of the times and the evacuation on the night of the fire indicates that the outcome may well have been positive had there been a properly operating smoke detector in the bedroom of fire origin on the night of the fire.

PART 5 BUILDING LAW AND THE FIRE

Recently, the State of Victoria has been working towards improving fire safety in public buildings. It has begun a process of requiring such buildings to conform to the same building law as applies to the private sector. This work commenced well before the fire at KRS. Historically, public sector buildings were not required to comply with the Building Code of Australia.

In order to ascertain the appropriate fire protection and safety systems applicable to a particular building, it has to be classified under the provisions of the Building Code of Australia. Classification will depend on the building's use and the nature of its residents. With the ULA fire audit, the Gardner Group were engaged as building surveying consultants for the upgrade project. Gardner identified the most appropriate classification as being 9A. By comparison, the MFB Report considered the appropriate classification under the Code to be Class 3.[25] Also a report of Peter Luzinat & Associates classified Units 30/31 as Class 3 (Ashlar also classified Unit 31 as 3).

The Warrington Report is helpful in dealing with the issues associated with the Regulations and the Code. The report comments that *'there have been conflicting views expressed as to the classification of the building'* and *'[t]he criteria nominated by the BCA does not address issues specific to the type of occupancy and facilities such as Kew Cottages do not sit easily within either the Class 3 or Class 9a categories'*.[26] In a more strongly worded conclusion, Warrington is of the view:

> *11.2 Current building regulations and the technical provisions within the Building Code of Australia are inadequate for facilities such as Kew Residential Services. The adoption of the BCA 1996 and the proposed amendments to the Victorian Building Regulations will address some of the major limitations.*[27]

In 1995, KRS renovated Unit 31, dividing the building into flats. This work created a complex building with difficulties for supervision and evacuation in the event of fire. The fire engineers at ULA had no knowledge of the renovations until they were complete. This was in spite of a recommendation in the ULA Report that fire engineers be involved in any renovations.

Management at KRS approached a building surveyor – Ashlar – who had no previous involvement at KRS. Because of a communication breakdown, the building surveyor was not aware of the true background of the residents at KRS. The surveyor was not told of the imminent fire upgrade. The Unit was not inspected either before or after the renovations so the significance of the type of resident or the fire safety issue was not discovered. Ashlar classified the building as Class 3. Had it been classified as Class 9A, some additional improvements in fire safety would

24 Transcript, p. 5362.

25 MFB Report, p. 136 et seq; see also p. 173.

26 Exhibit 201, p. 27.

27 Exhibit 201, p. 30.

have been required. Those improvements would have included: compartmentation; fire hose reels; smoke and fire detection system; alarm system/EWIS system; early fire hazard indices for linings; and egress provisions. The Warrington Report was of the view that *'these did not contribute to the fatalities which occurred on the 8 April 1996. However under other circumstances they could critically have affected the outcomes'*.[28]

Ashlar did not identify major fire safety issues during the certification process. It should have. Counsel for ULA submitted that the failures (during the renovation process for Unit 31):

> *have a strong temporal and causal relationship to the severity of the fire on 8 April 1996 in that:*
>
> - *the building works were completed only 6 months before the fire*
> - *the building works left unit 31 in the configuration and condition which it was in at the time of the fire (i.e. combustible materials, roof space, lack of detectors, fire walls and sprinklers)*
> - *fundamental fire safety issues were not identified during the approval process and no professional fire engineer was engaged*
> - *the fundamental object of the approval system viz. to ensure that the building was left in a safe condition was not achieved.*[29]

However, it is the failure by KRS management to advise the building surveyor of the upcoming fire upgrade that is the ultimate difficulty. When there is added a failure to advise the fire engineering consultant of the renovations to Unit 31, the problem compounds. The true picture of the role of the building surveyor can be seen in Mr Vasan's evidence:

> *Question: You were conscious, were you, as the works were proceeding, that the building when completed, in accordance with those works, would not meet acceptable fire safety standards?*
>
> *Answer: Yes, at that time, but we know we are going to do the upgrade within months, so it should have been done at that time.* [30]

It is accepted that KRS management took the risk associated with completing the renovations prior to the upgrade. Ultimately, management at KRS decided to proceed with the renovations knowing the risk and relying on the imminent upgrade.

PART 6 ROLES OF CONSULTANTS, CONTRACTORS AND MANAGEMENT IN CONTEXT

Many diverse issues arise as a result of advice from fire safety consultants, the work of a building surveyor and work undertaken by independent contractors on the fire alarm system at KRS. Throughout the body of the Findings, the roles and interaction of these various agencies are dealt with in more detail. Management played the most significant role in the diverse issues. Management bears the principal responsibility – by failing to follow advice and in not managing the risk.

It was suggested that the checks and balances of independent consultants and contractors *'fail the State of Victoria'*.[31] A critical examination, while identifying some real shortcomings, shows that the consultants in delivering advice did not fail. Principally, the failure was with the State in not heeding and managing the totality of the advice.

While some problems are identified in the detail of advice by the consultants (such as ULA), these are only factors in the wider systemic management problems. ULA did not complete a 'full audit' but only drew the attention of KRS/DHS to a number of deficiencies and risks with the fire safety system at KRS. Generally, apart from the addressable/sprinkler system, other recommendations made by ULA were not followed. ULA did acknowledge some shortcomings in its report, which were in summary:

- the maintenance of the detector system or circuitry
- the absence of circuit and detector plans

28 Exhibit 201, p. 30.

29 ULA Submission, pp. 37-38, para. 4.13.

30 Transcript, pp. 6016-6017.

31 State of Victoria Submission in Reply, p. 30 et seq. (Section E).

- the locked doors and
- fire-lighting risk.

Had KRS/DHS addressed the recommendations contained in other consultants' reports (or coronial recommendations), these issues would also have been covered.

ULA was on the PCG for the upgrade. However, despite a recommendation that a fire engineer's assessment be obtained for renovations, ULA was not informed of the 1995 renovations to Unit 31 until the residents were about to be moved back into residence. In addition, ULA was regularly on site – so the obtaining of advice would not have been difficult. These renovations significantly changed the way the Unit operated and created additional problems for supervision and evacuation at night with low staff numbers. There was an opportunity for KRS to manage the fire safety issues and the renovations. It chose, as is explained in evidence by Mr Vasan:

> *Question: You were conscious, were you, as the works were proceeding, that the building when completed, in accordance with those works, would not meet acceptable fire safety standards?*
>
> *Answer: Yes, at that time, but we know we are going to do the upgrade within months, so it should have been done at that time.*[32]

The failure of the maintenance contractor Jonkar to fulfil its responsibility to follow Australian Standards is far more significant. In addition to failing to provide plans or advise KRS of deficiencies, Jonkar had adopted a work practice of exchanging smoke with thermal detectors when false alarm problems occurred. It is likely that this work practice resulted in all of the smoke detectors in the bedrooms of Flat E being thermal detectors on the night of the fire. However, because of the identified inadequacies of the fire detection system, the required degree of comfortable satisfaction about the cause of the failure of the system on 8 April 1996 cannot be that degree of certainty about a lack of smoke detectors causing the problem.

At a minimum, Jonkar did not properly advise DHS of the deficiencies in the system. To that extent, at the very least, it failed the State of Victoria and the residents at KRS.

Despite Jonkar's failures over the years, there are a considerable number of mitigating factors that fall squarely on management's shoulders. These are:

- The fire detection system was in a state of disrepair when Jonkar was awarded the contract in 1991.
- There was a failure to consult Jonkar about the installation and placement in 1993 of 235 FFE detectors.
- Jonkar was not advised when renovations were to be carried out.
- Jonkar was not a member of the Fire Safety Committee and was not kept appraised of fire safety issues.
- Jonkar was not advised that any resident had fire-lighting tendencies.
- Jonkar was not given copies of the various reports on the fire safety system at KRS.

On balance, while Jonkar's performance warrants critical comment in a number of areas, that performance was essentially a symptom of overall systemic failure rather than the real genesis or exclusive cause of failure.

The role of the building surveyor Ashlar is considered. To the extent that it did not make the appropriate inquiries of KRS and the council as to fire safety issues, it failed KRS. However, what must be borne in mind is that Ashlar was not given any information on the imminent fire upgrade at KRS. It was kept in the dark. There was in fact a pattern of keeping parties in the dark as this also occurred to ULA: it too was not advised of a critical issue – the impending renovation works to Unit 31. Even those responsible for managing and caring for the residents at KRS did not receive adequate information internally on fire safety issues from the services area at the complex.

In respect of Wormald, it is considered that it is unlikely that it played any part in the failure of the system on the night.

The involvement of the contractors and the consultants such as ULA, Ashlar and Jonkar must be seen as factors in the wider picture leading to the tragic fire. Ultimately, management, whether it be at KRS, CMB level (or in the broader context by DHS), must share the overall responsibility for the incident. There are so many failures of communication at management level that it is difficult to discern precisely what information was given to the various consultants about the system. Certainly, one consultant was told very little; others were not informed about crucial issues at critical times. Advice was either not taken or ignored. Risks were taken without advice.

These failures of communication can be demonstrated by a failure to communicate in key areas, a failure to follow advice and, finally, a failure to manage the risk.

32 Transcript, pp. 6016-6017.

In summary, examples of the failure to communicate in key areas are:

- CMB did not seek the further involvement of Winn/Newton on presentation of the draft Dibben Report to CMB;
- CMB failed to advise KRS of the details of the 1993 Dibben Report;
- CMB did not advise (through the PCG) either KRS, ULA or both of additional interim and/or management issues in the Dibben Report. Senior management from CMB on the PCG had the detailed knowledge;
- The maintenance audit issue was not examined (sufficient recommendations were contained in the Dibben/ ULA reports);
- The issue of maintenance audit was not communicated adequately between KRS, DHS and BSA;
- DHS did not adequately communicate to KRS management and staff on the fire-lighting risk, which led to a failure by management to advise staff or a failure by staff to advise management on the fire-lighting risk;
- KRS management did not advise ULA (or the PCG) about the renovations to Unit 31;
- KRS management did not advise Ashlar (Paino) of the fire upgrade and safety issues at KRS;
- Jonkar was not advised of the significant fire safety reports, such as the Lumley, Dibben or ULA reports or the Fabric Survey;
- Jonkar was not advised of the renovations to Unit 31 (or at all);
- A fire engineer was not advised about the changing of smoke detectors to thermals in Unit 31 during renovations; and
- There was inadequate communication between divisions at KRS of the fire safety issues and recommendations.

Examples of the failure to follow advice are:

- Not following the Lumley, Dibben and ULA reports on maintenance (ULA refers to establishing the Fire Safety Committee and its role in maintenance);
- Not following the Lumley, Dibben or ULA reports on staffing levels in view of the fire safety risk at night;
- Not following the Lumley, Dibben or ULA reports on improvements in evacuation procedures;
- Not following the Lumley or Dibben reports on the importance of the Fire Safety Committee, and in particular, once the Fire Safety Committee was abandoned, in not following ULA's recommendations as to its re-establishment;
- Not following Dibben's holistic approach to the management of fire safety issues;
- Not following ULA's recommendation as to the need for fire engineering input on renovations or changes to buildings;
- Not following the Ministerial Guidelines on public building renovations;
- Not adequately following government directives on the installation of smoke detectors; and
- Not following the Fabric Survey on its recommendation relating to building renovations.

Examples of the failure to manage the fire risk (where there is clear knowledge of risk and a failure to act) are:

- Not following some of the advice in the various reports (note in substance that it is recognised that the advice on the upgrade was followed);
- Not undertaking an assessment of the 'likelihood of fire' in view of the number of MFB attendances at KRS;
- Not adequately managing the fire-lighting risk;
- Not examining the maintenance contract and the contractor's work in light of a continuing *'lack of faith in* [the] *system';*
- Not adequately examining the Building Code of Australia and/or the Australian Standards for compliance with the system, maintenance and building issues;

- Not adequately involving the maintenance contractor in the upgrade (or renovation) process;
- Not seeking advice from the PCG, the Gardner Group or ULA on fire safety and the 1995 renovations to Unit 31;
- Not adequately considering the consequences of the 1995 renovations to Unit 31 for fire safety management issues; and
- Not managing the return of the residents into Unit 31 after the renovations were completed (and before the upgrade) in light of a continuing *'lack of faith in* [the] *system'* and an awareness of the risk.

In this context of overall failure, no one consultant or contractor can be said to have contributed to the deaths of the nine residents despite any individual performance shortcomings that have been identified. Both historically and practically, the State of Victoria through its various agencies always was the party best equipped to source, scrutinise and distribute acquired learning as to the adequacy of the KRS fire safety system. It also had a monopoly on final decision-making as to how advice was implemented, and as to what systems it adopted for capital expenditure assessment and maintenance audit. As such it was the only party ultimately in the driver's seat.

PART 7 STATE OF VICTORIA'S (DHS) ACKNOWLEDGEMENTS OF DEFICIENCIES

The State of Victoria acknowledged a number of deficiencies in its systems operating at KRS. The acknowledgements cover fire detection and prevention systems, training, and evacuation procedures. Other areas of deficiencies identified are in managing fire-lighting risk, record keeping and training to identify and manage fire risk. The acknowledgements were made in the early and the closing stages of the inquest.

The importance of the early recognition of deficiencies for both the future prevention of similar systems failures and in the efficient management of the inquest investigation is acknowledged by the coronial service. The acknowledgements are significant and are detailed in Part 7.

PART 8 LEGAL ISSUES AND CONTRIBUTION

8.1 LEGAL ISSUES

8.1.2 INVESTIGATORY FRAMEWORK: THE *CORONER'S ACT* 1985

The *Coroner's Act* 1985 establishes jurisdiction in the coroner to investigate reportable death or fire. Under section 19 of the *Coroner's Act* 1985:

> *(1) A Coroner investigating a death must find if possible –*
>
> *(a) the identity of the deceased; and*
>
> *(b) how death occurred; and*
>
> *(c) the cause of death; and ...*
>
> *(d) the identity of any person who contributed to the cause of death.*

Similar provisions apply to 'fire' under section 36 of the Act.

Under both sections 19 and 36, a coroner may comment *'on any matter connected with the death (or fire) including public health and safety or the administration of justice'*.

8.1.3 APPLICABLE LEGISLATIVE AND/OR COMMON LAW FRAMEWORK

(1) DUTY TO RESIDENTS AT KRS

The State of Victoria owed a positive duty of care to the residents of Units 30/31 and, in particular, to those residents who were killed or injured in the fire. This duty arose:

(i) pursuant to the *Intellectually Disabled Persons' Services Act* 1986;

(ii) pursuant to the occupiers liability provisions of the *Wrongs Act* 1958; and

(iii) at common law as carer and occupier.

(2) DUTY TO STAFF AT KRS

The State of Victoria owed a duty of care to the staff working within Units 30/31 under section 21 of the *Occupational Health and Safety Act* 1985.

(3) NATURE OF DUTY TO RESIDENTS AND STAFF AT KRS

The duty owed by the State of Victoria to both residents and staff at KRS was non-delegable.

Section 4(a) of the *Intellectually Disabled Persons Services' Act* 1986 designates the Minister and the Department as having responsibility to administer the Act. Sections 5(c) and (d) provide:

> *(c) The welfare of an intellectually disabled person is the first and paramount consideration;*
>
> *(d) The needs of intellectually disabled persons are best met when the conditions of their everyday life are the same as, or as close as possible to, norms and patterns which are valued in the general community.*

Section 5(j) states that it is the responsibility of the State of Victoria to plan, fund and ensure the provision of, and evaluate services to, intellectually disabled persons according to the principles stated therein.

The deceased were all intellectually disabled persons who were incapable of taking care of themselves, and were under the care and protection of the State of Victoria in accordance with the *Intellectually Disabled Persons Services Act* 1986. They were resident at KRS, which was administered by the Department of Human Services on behalf of the State of Victoria. A legal duty to take reasonable care of the deceased was owed by the State of Victoria at common law and also under the Act.

Section 14B of the *Wrongs Act* 1958 (inserted by the *Occupiers Liability Act* 1983) imposes a duty of care on the State to the staff at KRS. The nature of the duty imposed is flexible, and a determination whether a duty has been discharged involves consideration of various factors, outlined in Part 8.

8.1.4 CONCEPT OF CONTRIBUTION

The concept of 'contribution' to the deaths and fire in the coronial context requires explanation as the coroner must, if possible, find the identity of any person who contributed to the cause of death or fire. A finding of civil and/or criminal liability is not part of the coroner's role. Moreover, such a finding should not be perceived in the public eye as being part of the coroner's reasoning when a finding of contribution is made. In *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1, Hedigan J stated:

> *On the other hand, one might say the other extreme, the submission was put that the concept of contribution requires no more than the conclusion that there is "some degree of blame" or "blame to some extent".*[33]

As to the relevant standard of proof required, Hedigan J refers to *Briginshaw v Briginshaw* (1938) 60 CLR 336, in which the 'Briginshaw Test' was formulated, which is the classic formulation as to the appropriate standard of proof to be used in civil cases. Hedigan J summarised the test as being that *'no finding of that kind (contribution) should be made unless there was comfortable satisfaction that negligence had been established as contributing to the cause of death'.*

The State of Victoria acknowledges that:

> *it had a personal duty to ensure that reasonable care was taken to provide a safe environment in which the clients could reside. This duty was probably a non delegable one arising from the fact that KRS had undertaken the care, supervision and control of its intellectually disabled clients, thereby assuming a particular responsibility for their safety in circumstances where those clients or their legal representatives would reasonably expect that due care would be exercised for them.*[34]

The State does not concede, however, that it is legally liable in respect of contribution for any and all breaches of duty by its independent contractors.

33 *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1, Hedigan J at 16.

34 State of Victoria Submission in Reply, p. 219, para. 5.3.

Further, the State of Victoria argues that the concept of contribution under the *Coroners Act* 1985 appears to encompass individuals, and not government departments. It submits that:

> *[t]he* Interpretation of Legislation Act *1984 defines a person as including a body politic or corporate, as well as an individual. Save to the extent that the Department has some corporate existence for limited purposes, it would not be a body corporate nor an individual. A "body politic" as Hedigan J observed in Hallenstein's case at page 43 is "the nation in its corporate character: the State." It is therefore submitted that it is appropriate for the MFB and the Parents' Association to have addressed their criticism to the State of Victoria rather than any individual department.*[35]

Finally, the State of Victoria submits that *'careless references'* have been made to DHS as being responsible for actions that have occurred *'decades before DHS was formed'*.[36] That reasoning is adopted, and any findings pertaining to contribution are in respect of the State of Victoria.

8.2 CONTRIBUTION TO THE FIRE AND DEATHS

Any contribution by the State of Victoria (or by its agents DHS and/or KRS) to the fire and deaths must be seen in the context of a major upgrade to all of the hardware fire systems which was weeks off completion on the night of the fire.

It is found that:

A. The State of Victoria contributed to the deaths of the nine intellectually disabled residents in three main ways:

(1) The State of Victoria owed a duty of care to the residents under its care to protect them by providing an efficient, safe and proper fire safety system. It accepts that it owed such a duty.

Despite numerous warnings over the years, the State of Victoria did not provide such a system, but it must be borne in mind that it was in the process of doing so. This finding against the State of Victoria spans the failure of several governments and their various departments.

The warnings can be seen as commencing as long ago as 1968 with six deaths in the Willsmere fire. However, recent history documents warnings from the MFB in 1986 and by a letter from one of the State of Victoria's managers at KRS, Mr Taylor, in 1989:

> *You should be aware that over 750 intellectually disabled people are accommodated at this Centre. Many of these people have profound physical and intellectual disabilities and would be placed at enormous risk in the event of a fire.*[37]

Once a fire started, particularly at night, the residents certainly were at *'enormous risk'*. For that reason it is clear that ten years is too long to wait to address the many problems with the fire safety system at KRS.

(2) The State of Victoria by its agents DHS/KRS contributed to the deaths of the nine intellectually disabled residents by not providing adequate interim fire safety measures to protect the residents.

(3) The State of Victoria through its agent DHS contributed to the fire and the deaths of the nine intellectually disabled residents by failing to adequately monitor, supervise or manage the fire risk behaviour of one of its residents, Paul.

Implicit in the State's duty to its residents and staff is the responsibility to assess and manage risk and to provide a reliable fire safety system as far as is practicable free of deficiencies.

B. It is likely that Jonkar also had a significant and ongoing role in creating or continuing an unsafe fire environment at KRS at the relevant times. It continued to breach Australian Standards and failed to advise KRS/DHS or BSA of the parlous state of the fire safety system that it was maintaining. The evidence shows that it continued to replace smoke detectors with thermals as a 'temporary' measure during renovations with the intention of later re-instating smoke detectors. There is no confidence that re-instatement was in fact done.

However, on the required standard of proof, the evidence is not such as to allow that comfortable degree of satisfaction to reach a finding that Jonkar contributed to the deaths of the nine intellectually disabled residents. Jonkar's role, while unsatisfactory on many counts, needs to be seen in context. It must be noted that Jonkar was not advised of the renovation works to enable it to plan for possible interference with the alarm system.

35 State of Victoria Submission in Reply, p. 228, para. 5.21.

36 State of Victoria Submission in Reply, p. 227 para. 5.20.

37 Exhibit 159 'JT12' – Letter dated 7/8/89.

It was not given copies of the many reports and surveys on the fire safety system at KRS. The State of Victoria did not fully and adequately inform, instruct or monitor its involvement, and that failure was significant.

C. It is likely that the respective roles played by ULA and Ashlar were factors in the final stages of a systemic management problem that beset the issue of fire safety at KRS for a number of years. However, on the required standard of proof, there is not that comfortable degree of satisfaction for a finding that those factors were sufficient to lead to a conclusion that either ULA and/or Ashlar contributed to the deaths of the nine intellectually disabled residents.

ULA admitted that it did not sufficiently detail some areas of fire safety in its 1994 Report. In 1995 Ashlar failed to ask sufficient questions and make the required inquiries about fire safety issues for the planned renovations to Unit 31.

It must be borne in mind that ULA was responsible for providing the necessary technical input to ensure that the upgrade occurred with a sprinkler system. Further, ULA was not given, by CMB, a key fire safety report which had been undertaken the previous year.

However, attempts to sheet home contribution to both ULA and Ashlar ignores the fact that KRS management did not advise one of the renovations and the other of the fire upgrade. At some levels of management at KRS, it was apparently decided (as put by Mr Vasan) to run with the risk:

Question: You were conscious, were you, as the works were proceeding, that the building when completed, in accordance with those works, would not meet acceptable fire safety standards?

Answer: Yes, at that time, but we know we are going to do the upgrade within months, so it should have been done at that time.[38]

The advice given by ULA to involve a fire engineer in any future renovations did not operate to affect that choice. Advice was given some 21 months before the fire and ignored in significant areas. The failure of Ashlar to adequately identify fire safety issues must flow from a lack of knowledge of the upgrade and its *raison d'être.* Ultimately, the decision by some of KRS management was to proceed knowing the risks and banking on the imminent upgrade. Ashlar's work did not affect that choice.

It is the failure to advise both ULA and Ashlar of significant issues relating to fire safety at KRS, combined with inaction on a number of reports, that does not leave that *'necessary degree of satisfaction of mind'* for a finding of contribution. It must also be remembered that Direct Care management at KRS was not advised of important fire safety issues by other areas of KRS management.

D. In view of the findings of contribution against the State of Victoria, it is unnecessary to make findings relating to contribution in respect of other critical areas of fire safety discussed throughout the body of the Findings. These are important factors involving:

- Fire drills and evacuation;
- Training; and
- Locking of doors.

PART 9 COMMENTS AND RECOMMENDATIONS

9.1 INTRODUCTION: THE FUTURE

Many of the parties have adopted what the Metropolitan Fire Brigades Board aptly described as a *'prescription for prevention'*.[39] In particular, the submissions of the Kew Cottages & St. Nicholas Parents' Association, the Health and Community Services Union, the Villamanta Legal Service, the Office of the Public Advocate, Wormald, Umow Lai & Associates, the Building Services Agency, the MFB and the State of Victoria have developed a primary focus on learning from this tragic fire.

The importance of identifying and rectifying deficiencies following the fire and deaths at KRS has been well recognised by the State of Victoria. It has *'demonstrated'* a preparedness to *'set in place a system of reform before*

38 Transcript, pp. 6016-6017

39 See MFB Submission, 'frontispiece' to Submission.

the conclusion of the inquest'.[40] The reforms are not limited to KRS but will extend to other forms of accommodation provided by DHS and to non-government areas funded by the department. DHS has developed a *'Fire Risk Management Strategy'* which is discussed in the State's Submissions in Reply (see Appendix 3.2).

From about 1993 the government began a program of audits of public buildings and, as evidenced by the work on the upgrade of the fire services at KRS, commenced to address some of the identified problems. In its Submission in Reply, the State of Victoria indicated that it is providing an *'amount of $75.5 million ... to continue the program of fire safety audits and works to upgrade Department facilities over the next three years'*.[41] The funding was announced in the 1997/98 budget and is available *'for the progressive upgrade of fire safety for Department owned or operated buildings. The audits have identified high and medium priority works progressively implemented across the State'*.[42]

Where residents are disabled, elderly or incapacitated, it is essential that the appropriate fire prevention, warning, reduction and evacuation system is employed. Initially, it is important to consider the quality of the building and environs (including materials and layout), products with potential fire risk, furniture and bedding. Fire-lighting or risk behaviour and smoking need to be managed. All fire prevention must start with the aim of reducing the potential for fire developing. Where work is undertaken on an upgrade of fire systems, the management of safety in the interim is vital. This case is a salutary illustration of the point.

Fire warning and evacuation systems must be developed to cover the needs of the residents, staff and public in the event that a fire develops. Fire reduction and protection systems need to address the ever-present potential for rapid fire conflagration. All of these systems need to consider the disabilities or particular nature of the residents and their environment. In particular, agencies caring for the disabled have a considerable responsibility for their safety.

Without management, fire can spread in an enclosed room (the size of a normal bedroom or living room) to engulf the area to a temperature of approximately 600 degrees Celsius within about six to seven minutes. Smoke and toxins developed during a fire can kill well before that. Fast-response sprinkler systems can douse fires well before a room is engulfed.

9.2 SPRINKLERS WILL SAVE LIVES

There is no doubt that sprinklers will save lives. The disastrous fire at KRS has been recognised as highlighting the value of automatic sprinkler systems. It should be a salutary lesson that sprinkler systems have been utilised successfully in buildings in Australia for about 100 years.

The State of Victoria noted that Regulation 5.15 of the Building Regulations 1994 (which came into operation on 1 August 1997) requires AS 2118.4-1995 sprinkler systems to be installed in all defined residential care buildings within five years.

RECOMMENDATION 1

Full fast-response residential sprinkler systems for buildings housing the intellectually disabled is supported. Partial sprinklering is not.

Moves towards a phased compulsory introduction of residential sprinkler systems for buildings housing the intellectually disabled is supported.

When the issue of mandatory requirements for residential sprinkler systems is considered, the elderly, the sick and the disabled are recognised as being in areas of high risk. Over the years coroners have made a number of recommendations for sprinkler systems in these areas. Accordingly, the requirement for the mandatory introduction of automatic sprinkler systems in residential care facilities is supported.

40 State of Victoria Submission in Reply, p. 46.

41 State of Victoria Submission in Reply, p. 48, para. 1.6.

42 State of Victoria Submission in Reply, p. 57, para. 2.8.

9.3 AUDIT REPORTS: NEED TO DEFINE AND MANAGE

9.3.1 NEED FOR REGULAR FIRE AUDITS

The need for regular fire audits has been well canvassed in the recommendations of the parties in this inquest. The benefits of a regular and systematic audit process are obvious. The failure to review fire safety and management systems regularly can only operate to increase the potential for exposure and risk of any agency to disastrous fire. As procedures become too entrenched in daily work life or hardware begins to become obsolete, the need for regular audit increases.

In this inquest, it could not be said that the problem was one of a lack of reporting. The problem was, when looking at the totality of the reports, that many of the recommendations were ignored. The totality of the recommendations in the various reports were not managed.

9.3.2 NEED TO DEFINE

The confusion associated with audits and the precise extent to which the reports operated to affect the decisions on fire safety in this incident is a moot point. Certainly, the need to define the operational limits of particular types of audits has been identified.

Where a governmental or private agency requests an audit, there is a need to clearly specify its operational limits. This cannot be done accurately without knowledge of the basis on which a particular type of audit is conducted. In this regard it is essential that the fire protection industry assist the community and provide definitions and extent of coverage of particular types of audit.

RECOMMENDATION 2

That Standards Australia (with the fire protection industry) develop a Standard governing the scope and methodology of the various types of fire audits.

9.3.3 AN ' AUDIT TRAIL'

In undertaking any audit, there is a need to review all earlier consultants' reports and/or fire audits/fire reports to assist in determining the extent of risk and to identify where previous problems have not been rectified.

Management has a clear role in drawing these documents together to assist in the process of fire audit. Where an earlier report has been done, it is essential that it be supplied to the consultant undertaking the audit. Management also needs to document responses to recommendations.

When the development of an 'audit' standard is being considered by Standards Australia there is a need to ensure that reports affecting fire safety are linked. An 'audit trail' between the various reports is essential to minimise the risk of issues remaining unattended.

RECOMMENDATION 3

Any standard for audits developed by Standards Australia should include a requirement for a consultant to review previous audits, fire reports and consultants' surveys.

RECOMMENDATION 4

Any standard developed by Standards Australia should include a requirement for management to supply previous audits, fire reports and consultants' surveys to the consultant undertaking any audit or survey.

9.3.4 NEED TO MANAGE AUDIT REPORTS AND RECOMMENDATIONS

This inquest has demonstrated the need for a managed 'audit trail'. To assist in that process, sound management practice would dictate that copies of all fire audits, reports, surveys, etc pertaining to one building or complex be kept together. This would assist in a subsequent review or audit process.

The need to manage recommendations has also been demonstrated. Numerous recommendations of reports and surveys were not addressed. Thus any standard dealing with audits may need to specify mechanisms for managing

the recommendations. That does not mean, however, that audit recommendations are required to be followed. What is necessary is to establish a system for appropriately considering and documenting responses to recommendations flowing from audits.

RECOMMENDATION 5

Any standard developed by Standards Australia pertaining to audit methodology should include a requirement that management ensure copies of all audits, reports and surveys pertaining to fire safety issues be kept in one file relating to the relevant complex or building.

RECOMMENDATION 6

Any standard for audits developed by Standards Australia should include a requirement for management to periodically document, assess, review and report on the various recommendations contained therein.

9.4 MAINTENANCE: 'CONTRACTING OUT' AND THE REQUIREMENT FOR 'AUDIT'

At KRS the maintenance contractor performed its work for a number of years with no technical supervision. KRS considered that the maintenance contractor's work was being overseen by the government building services agency (BSA). Apparently, while both BSA and DHS knew that this was not the case, the client KRS was not advised. The agreement between the contractor and BSA specified compliance with Australian Standards in the maintenance work.

The fire and subsequent investigation disclosed numerous breaches of Australian Standards. Those breaches included regularly exchanging smoke detectors with thermals (allegedly on a temporary basis). Safety was compromised in a number of areas. With no 'technical audit' of the contractor's performance, the potentially unsafe situation continued.

While performance-based maintenance of essential services (including fire safety equipment and services) is specified under the Victorian Building Regulations 1994,[43] without some form of independent checking the risk of a repeat of the KRS situation cannot be eliminated.

Where fire safety is concerned, an independent 'technical audit' of a maintenance contractor's work is essential. It may be necessary to consider requiring that independent 'technical audit' of maintenance contracts be built into the Australian Standards.

RECOMMENDATION 7

An independent 'technical audit' should be part of any maintenance contract of fire safety systems. While it is recognised that a 'technical audit' of maintenance may not be a regular occurrence, a system should be developed to ensure that maintenance work is checked.

If appropriate, a provision should be inserted into the relevant Australian Standards requiring an appropriate level of independent 'technical audit' of maintenance contracts and works.

9.5 INTERIM SOLUTIONS: AN INDUSTRY STANDARD OR CODE

During the inquest, the MFB developed an example 'Fire Detector System' inter-locked to 9 volt smoke alarms. The system was designed and demonstrated approximately two weeks after the issue of low cost interim measures was raised at the inquest. The system's rapid development serves to illustrate the potential for lateral thinking in finding temporary solutions to fire safety problems.

During the planning and early implement stage for the upgrade at KRS, 'interim' hardware measures were discussed. Once interim hardware solutions were found not to be an option (because they were not low cost, integratable and were not approved), other management solutions were not considered. A broader 'holistic' approach to the

43 Victorian Building Regulations 1994, Part 11 – Maintenance. This part specifies areas such as exit doors; fire brigade connections; fire control centres; fire control panels; fire curtains; fire dampers; fire detectors and alarm systems; fire extinguishers; sprinkler systems; etc. (the fire list is far more extensive).

management of risk and the introduction of non-hardware interim solutions was not taken. These may have included staffing levels at night, improved evacuation procedures, managing fire-lighting risk or even in not returning the residents to Unit 31 until the upgrade was complete.

There was clear knowledge of the risk to residents and staff and an awareness that the upgrade would take some months to complete. In these circumstances interim solutions were necessary. The later alteration to Unit 31, dividing it into flats, increased the difficulties for staff in the supervision of residents and emergency management. This made interim solutions even more necessary.

The experience of the fire at KRS has highlighted the need for the fire protection industry to be aware of the various types of interim solutions available (hardware or management). Systems need to be developed to fast-track approval procedures for interim hardware solutions in appropriate cases. It is noted that the State of Victoria is including an 'interim works clause' in the standard brief for fire audit and fire risk analysis.[44] The MFB makes a telling point in its recommendations:

> *The Fire Protection Industry must change their philosophy in relation to interim systems. Whilst acknowledging that it is the responsibility of fire engineers to develop appropriate interim systems, it seems that there is a consensus view among fire engineers that the interim systems must comply to standards or be elaborate in nature. This is not the point – interim systems are there to provide short term corrective measures for otherwise deficient systems and may comprise of simple measures. They are not meant to bring systems up to standard – a full fire upgrade may be necessary for that.*[45]

RECOMMENDATION 8

That Standards Australia (with the fire protection industry) develop a standard governing the scope of interim hardware (or technical) solutions; or
the fire protection industry develop a code governing the scope of interim hardware (or technical) solutions.

(Any standard/code developed should stress the need to consider other interim management solutions.)

RECOMMENDATION 9

Where approval of the technical specifications of an interim hardware solution is required, a fast-tracking system should be developed.

All relevant approval agencies need to be identified and involved in the process.

9.6 A SYSTEM FOR FIRE AND EVACUATION PROCEDURES

The need for adequate systems to prevent or manage fire and evacuation procedures for the intellectually disabled is obvious. The importance of effective fire drills and evacuation training and procedures can be seen from the events on the night of the fire at KRS. Although, in the final analysis, the evacuation procedures may not have affected the eventual outcome, there remained potential for further disaster:

> *Fire crews commenced an immediate attack on the fire and, based on information supplied by persons that identified themselves as staff of the Kew complex, initially believed that they were dealing with a fire fight only and that all occupants had been evacuated from the complex.*
>
> *As the incident unfolded, it became obvious that not everyone could not have been evacuated as there were still residents and staff milling around Building 37. ...*
>
> *It wasn't until almost 26 minutes had passed that it could be established that as many as 10 residents could be missing.*
>
> *This fire reflected the need to ensure that those charged with the care of others follow a predetermined plan of action, established by clear concise and workable emergency procedures. It is also important that the procedures be practiced by those expected to implement them.*[46]

The State of Victoria (DHS) has appropriately developed a system to deal with fire drills and evacuation in departmental premises (see Appendix 3.2). It is noted that Australian Standard AS 3745-1990 'Emergency control

44 See Appendix 3.2, para. 2.38.

45 MFB Recommendations, para. 73 (see Appendix 3.3).

46 MFB Report, p. 202.

organization and procedures for buildings' is referred to in the response to the Parents' Association recommendations. The State indicates that its protocols largely comply with the standard. AS 3745 provides guidance on:

> *the establishment of an Emergency Control Organization (ECO), sets out recommended procedures for the safety of people in buildings during emergencies and addresses the authority of the ECO personnel.*[47]

However, there is no reference in the evacuation procedures to the Australian National Competency Standard Competency Standard CS-FP-001-1995. If this standard has not been used in the development of the protocol, it may be appropriate to re-consider the issues in the light of the standard.

RECOMMENDATION 10

That DHS examine the application of the Australian National Competency Standard – Competency Standard CS-FP-001-1995 for fire emergency response.

9.7 MANAGEMENT: RESPONSIBILITY TO MANAGE RISK

The fire at KRS has highlighted the fact that management should be aware of its responsibility to manage fire risk. In this case management failed to consider thoroughly and address appropriately all of the recommendations of the fire brigade and consultants.

RECOMMENDATION 11

That the State of Victoria consider reminding public sector managers of the general responsibility to manage fire risk. This could be addressed through regular management training programs and government publications.

The lessons learnt from the KRS fire need to be reinforced in the area of public sector management.

9.8 FAST-TRACK FUNDING

Where a fire audit or investigation indicates major safety concerns over a number of years, it is essential that funding issues be prioritised. Where concerns are combined with areas of moderate to high risk and a degree of urgency, rapid access to funding becomes a crucial issue. It may be necessary to consider methods of balancing competing priorities to provide a mechanism of 'fast-track funding' for major fire safety issues. It is essential that delays in this area be minimised.

The State of Victoria in its Reply has recognised the importance of improving the speed of access to funding in the area of fire safety by its comment:

> *The delay in the obtaining of a fund allocation from the time that Mr Taylor first submitted the upgrade as a priority capital works project should be a matter of justifiable concern. The State of Victoria accepts much of the criticism that has been raised by various parties concerning this delay. The functioning of government and the bureaucratic process accounts for much of this delay. The State of Victoria recognises that the constructive criticism that has been raised will lead to the reform of some of these processes.*[48]

RECOMMENDATION 12

That the State of Victoria consider procedures to improve the speed of access to funding where major fire safety issues are concerned.

9.9 BUILDING ISSUES

In its recommendations, the MFB echoed the concerns of a number of the parties to the inquest when it said that:

> *[t]he deficiencies in the consideration and implementation of the renovations resulted in part from inadequacies in the building regulations regarding premises used for the provision of residential care accommodation and regarding the renovation of such premises.*[49]

47 Australian Standards – Index.

48 State of Victoria Submissions in Reply, pp. 261-262, para. 83.

There was confusion over the building classification of facilities such as KRS:

> *But the real problem identified in the inquest is the pressing need for the reform of the BCA so that the fire safety requirements of residential care facilities are properly prescribed.*

The State of Victoria has been moving down the path of reform in the area of building law as it applies to the public sector and safety. It is worthy of note that as of 1 August 1997 government buildings are subject to the provision of the *Building Act* 1993. This is a commendable initiative, remedying what must have seemed to onlookers a most peculiar dispensation.

The Warrington Report cautions that:

> *9.12 The planned modifications to the building regulations will not address more subtle design considerations for fire safety such as fire prevention through the use of flame retardants, simple building layouts to facilitate ready evacuation and well illuminated sheltered assembly points for evacuation, and may not address the limitations of the current classification system.*[50]

It is essential that these subtle difficulties be overcome.

RECOMMENDATION 13

That a consultative process be adopted to ensure that any anomalies or difficulties in classification of residential care facilities under the* Building Act *1993 be overcome.

RECOMMENDATION 14

That a consultative process be adopted to ensure that any fire safety problems associated with residential care facilities and building law be overcome.

The KRS fire highlights the need for caution by building surveyors when dealing with fire safety issues in the public or private sector. The difficulties associated with construction or alteration to buildings housing the intellectually disabled add to that requirement for caution.

There are a number of recommendations by the parties which direct attention to the need for added education, training and improvements in procedures for building surveyors. With changes in governmental regulations for fire safety in public buildings and performance-based requirements, these are endorsed as an important step in fire safety.

9.10 FIRE SAFETY AND 'CONGREGATE CARE'

The Office of the Public Advocate indicated concern about the fact that *'the characteristics of congregate care inevitably and foreseeably deleteriously affect the safety of dependent, long term residents with intellectual disabilities'*.[51] He points to the fact that it is fundamental to consider the physical *'environment within which the care is provided'*.[52] Although the issue of the desirability or otherwise of congregate care is not within the jurisdiction of the inquest,[53] that issue has been raised in the context of fire safety. As is put by the Public Advocate, the grouping of large numbers of *'residents in one another's company in congregate care units such as Unit 30/31'* has an *'immediate safety outcome'*.[54]

Nevertheless, while many of the issues on congregate care are not within the Coroner's brief, some issues associated with fire and large accommodation units like Units 30/31 may require review. What can be said is that larger accommodation units require well-managed technological and human resource solutions in order to reduce the risk associated with fire. Full sprinklering is obviously part of the solution.

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49 MFB Recommendations (see Appendix 3.3, paras. 70-71).

50 Exhibit 201, p. 28.

51 Public Advocate's Submission, p. 34.

52 Public Advocate's Submission, p. 34.

53 But see an argument in Lloyd, A., *Payment by Results; Kew Cottages' First 100 Years 1887-1987* (First published in 1987 by the Kew Cottages & St. Nicholas Parents' Association), Chapter 10 'Bureauracy rampant', pp. 45-51. See also a comment by Mr Phillip Adams on the back cover of the book: 'The stigma of intellectual disability must be obliterated and its victims welcomed into our community. There is still a strong case for places like Kew Cottages as alternatives, as options'.

54 Public Advocate's Submission, p. 162.

9.11 MANAGEMENT OF FIRE-LIGHTING BEHAVIOUR OR RISK

The fire and nine deaths at KRS highlight the need for agencies with a responsibility to care for residents who may have disabilities by way of age, infirmity, illness or otherwise to manage the issue of fire-lighting risk or behaviour. In this case, the issue of the potential fire-lighting risk involving a resident was not appropriately managed or investigated. Staff had received no training to enable them to assess risk, and the problem, once identified, did not receive the attention that was required.

Where an individual displays fire-lighting behaviour or risk actions, it is vital that the issue be managed. The problem may include not only dealing with the individual but considering smoking policy (which may mean dealing with staff use of cigarettes) or restricting access of residents to fire-lighting implements (perhaps by the use of childproof cigarette lighters). The consequences of the failure to manage fire-lighting risk or behaviour are clearly demonstrated by this fire.

There is considerable guidance on this issue contained in the management policies adopted by DHS (see Appendix 3.2). Nevertheless, additional specialist advice may be required from agencies such as the Royal Children's Hospital, the MFB or the Country Fire Authority (CFA).

9.12 FIRE AND 'OCCUPATIONAL HEALTH & SAFETY'

At least one member of staff was injured during the evacuation. Others were placed at risk in the aftermath of the fire. Difficulties beset the rescue because of an inadequate fire safety system in a building that has been described as being of '*labyrinthine configuration*'.[55] Poor fire drill and evacuation training cannot have helped.

The management of fire risk and the intellectually disabled has clear consequences for the safety of staff. Staff may be trapped in a fire or injured during rescue attempts, which are sometimes fraught with difficulties because of the disabilities of the residents or the design of the building.

Management at KRS failed to advise staff adequately of the risks and did not provide the appropriate training or safe systems of work.

9.13 LEARNING FROM THE KRS FIRE: PARTIES' RECOMMENDATIONS

A number of the parties to this inquest provided the investigation with considered recommendations for systems improvements. The recommendations are detailed in Appendix 3. The State of Victoria and Villamanta Legal Service have reviewed some of those recommendations. These responses are contained in Appendix 4. It is noted that the State agrees with several of the parties' recommendations.

The importance of the recommendations for improvements in our community's fire safety systems cannot be underestimated. The recommendations vary from issues relevant only to KRS to many applicable to general fire safety. It is essential that each recommendation be considered by agencies with the appropriate expertise.

Accordingly, the following recommendations are made:

RECOMMENDATION 15

That DHS auspice a review of all of the parties' recommendations delivered with the Submissions and Replies. Any review committee should include representatives of the MFB, the CFA and BSA. It also may be useful to include the Building Control Commission and the Victorian WorkCover Authority. Any review of the recommendations may identify areas of:

55 Parents' Association Submission, p. 29, para. 81.

- ***general or specific application to community fire safety;***
- ***application to KRS; or***
- ***application to other areas involving the disabled.***

Where the review process identifies recommendations which may have general application (or application to other areas involving the disabled), they may need to be directed to the appropriate agency, such as the Australian Fire Authorities Council, Standards Australia, Australian Fire Protection Association, Institution of Fire Engineers, etc.

Where the review process identifies further potential for improvement in the management of fire safety at KRS no doubt that will be fed into DHS's model system.

The review would need to consider consulting with Wormald, ULA, the Health and Community Services Union, the Office of the Public Advocate, Villamanta Legal Service and the Kew Cottages & St. Nicholas Parents Association.

9.14 GENERAL ISSUES

Several general issues involving Paul, the fire investigation and commendations to various individuals are considered in this subsection.

9.14.1 FUTURE MANAGEMENT OF PAUL

Counsel for Paul, Mr John Smallwood, indicated some concern about Paul's future management in the event that it was found that he lit the fire. Counsel submitted that:

> *[i]f he be formally found to have lit the fire the very real fear is that he will effectively be kept in circumstances where those responsible for his care will be under extreme pressure to avoid a repetition. Because of his extremely limited comprehension of the world around him it would be seen by some that the only effective means of such an avoidance would be the almost total deprivation of his freedom and privacy.*[56]

It is recognised that DHS will no doubt ensure that Paul is appropriately managed, balancing his needs under the *Intellectually Disabled Persons' Services Act* 1986 for a degree of freedom and privacy with the issue of safety. It is acknowledged that Paul's management plan would need to accommodate competing issues.

9.14.2 THE INVESTIGATION AND 'FIRE TEST'

Following the fire, an investigation for the Coroner was undertaken jointly by the Victoria Police (Arson Squad), the Fire Investigation Unit of the Metropolitan Fire Brigade and the Victorian Forensic Science Centre. The investigation was run under the protocols developed by the 1995 '*Victorian Joint Fire Investigation Procedures'*.

The MFB, in cooperation with the other investigatory agencies, developed a full 'fire test' that was conducted at leased premises at Scientific Services Laboratory, Port Melbourne. Considerable resources were committed by the MFB to the Port Melbourne 'fire test' with reconstructed, furnished units and monitoring equipment. In addition, a 'test room' was built to demonstrate the effectiveness of fire retardant bedding, plaster board, smoke alarms and a fast-response sprinkler system. A number of the parties were present during the major fire test demonstration at Port Melbourne. Testing was also conducted at the MFB's 'Fire House', Abbotsford. Prior to the testing, the Brigade undertook computer modelling with the assistance of the Centre for Environmental Safety and Risk Engineering at Victoria University of Technology.

The fire test has been an invaluable tool in assisting the understanding of many aspects of 'fire' in the residential situation. The professional level of the work undertaken by the MFB, Inspector Martin and the officers at the Fire Investigation Unit to assist the inquest is highly commendable. Throughout the inquest, the MFB provided an objective and valuable level of assistance to the Coroner.

56 Submission by Counsel for Paul, p. 2.

9.14.3 COMMENDATIONS

PUBLIC SAFETY

The MFB commends *'the KRS staff who were engaged in the evacuation effort for the contribution they made in uniquely challenging circumstances. The efforts of Mr Frlan in particular deserve special commendation. The result was that all disabled clients from Flats A, B, C and D and one survivor from Flat E (a total of 36 persons) self-evacuated or were evacuated safely from Unit 30/31'*.[57]

The court joins with the MFB Submission on this issue. All the fire officers involved in the incident and evacuation effort are deserving of commendation for their work. On any view, Mr Calder's action is deserving of special commendation. Mr Morris's actions are also commendable. It is considered that KRS staff member, Mr Chea Earpeng, should be added to the list.

9.15 CONCLUSION

Fire safety systems must be considered as a total package of risk management, equipment, maintenance, training and fire and evacuation drills. Once systems are established, audit must be regular and rigorous. Where disabled or immobile persons are concerned, the importance of the total package cannot be underestimated. Early warning to residents, staff and firefighting agencies in the event of the first signs of fire is vital to maximise the potential to reduce the risk of injury and death. Well-developed evacuation procedures are vital. Modern, fast-response residential sprinkler systems designed to reduce fire spread are essential. Building design layout, taking into account fire risk and potential spread, is an important consideration. Where locked doors restrict residents, it is vital for efficient and safe evacuation that automatic door latch release mechanisms be included in overall layout.

In conclusion, it is essential that the lessons of this fire are addressed by our community and also by those charged with the responsibility of caring for the disabled.

Graeme Johnstone
State Coroner
17 October 1997

Assisted by Messrs Graeme Hicks and Michael Hennessy (instructed by Ms. Vanessa Ash of the Office of the Director of Public Prosecutions)

57 MFB Submission, p. 39, para. 91.

APPENDIX 2 PLANS AND CHRONOLOGIES

2.1 Explanation of Smoke Detectors and Smoke Alarms[1]

2.2 The 'January Plan'[2]

2.3 The Wormald 'End of Line Resistor' Plans

- 2.3.1 Flat E – Figure 1
- 2.3.2 Flat E – Figure 2
- 2.3.3 Flat E – Figure 3

2.4 The 'McCumisky Plan' (MFB)[3]

2.5 The MFB Chronology of Events at KRS[4]

2.6 The MFB Chronology of Known Detector Damage[5]

2.7 Villamanta Legal Service – Summary of Recent Fires at KRS[6]

2.8 Villamanta Legal Service – Chronology of Events about Circuit 39[7]

1 Exhibit 165.

2 Exhibit 139.

3 Exhibit 186.

4 Exhibit 195 and attachment to MFB Submission.

5 Attachment to MFB Submission.

6 Appendix 10.2 to Villamanta Legal Service Submission.

7 Appendix to Villamanta Legal Service Submission.

APPENDIX 2.1

Explanation of Smoke Detectors and Smoke Alarms

SMOKE DETECTOR

A smoke detector is a device designed to sense the products of combustion in the early stages of a fire developing.

A smoke detector does not incorporate an audible alarm within its own workings and relies on a separate device being connected.

A smoke detector is covered by Australian Standard 1670 and is normally installed in industrial or commercial situations.

There are several different types of technology employed, however the main types are ionisation and optical (refer to note for explanation of operation of both types.

SMOKE ALARM

A smoke alarm is a device designed to sense the products of combustion and provide early warning, with regard to fire, to the occupants of a structure.

This device, unlike the smoke detector, incorporates an audible alarm within the body of the device.

The smoke alarm is covered by Australian Standard 3786. These devices are normally installed in domestic situations however, the smoke alarm is often recommended as an interim measure during an upgrade of an industrial or commercial structure or other occupancies where AS 1670 does not apply.

The smoke alarm will generally provide earlier warning than a smoke detector due to the secondary sensing design of a smoke detector.

The smoke alarm can be powered by a stand alone 9 volt battery or wired directly to the 240 volt main supply with a 9 volt battery backup in the event of power failure.

Both the smoke alarm and the smoke detector incorporate a light emitting diode (LED) that will function intermittently to show that the device is energised.

The LED will function continually during actual operation of the detector/alarm. This allows those responding to the alarm (where multi alarms are fitted) to identify which device has operated.

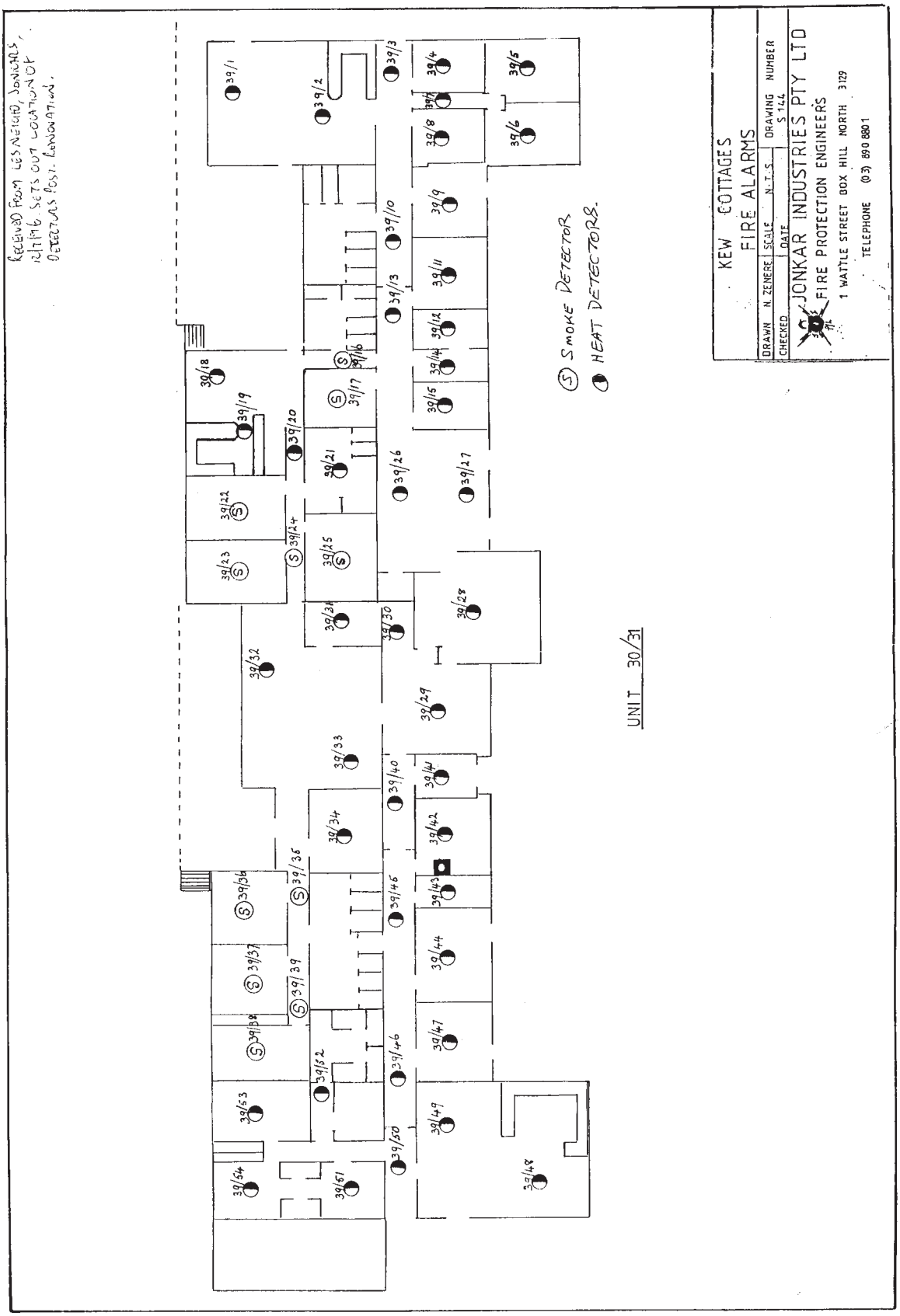
Note:

Ionisation Type: a detector which responds when smoke having entered the detector, causes a change in ionization currents within the detector.

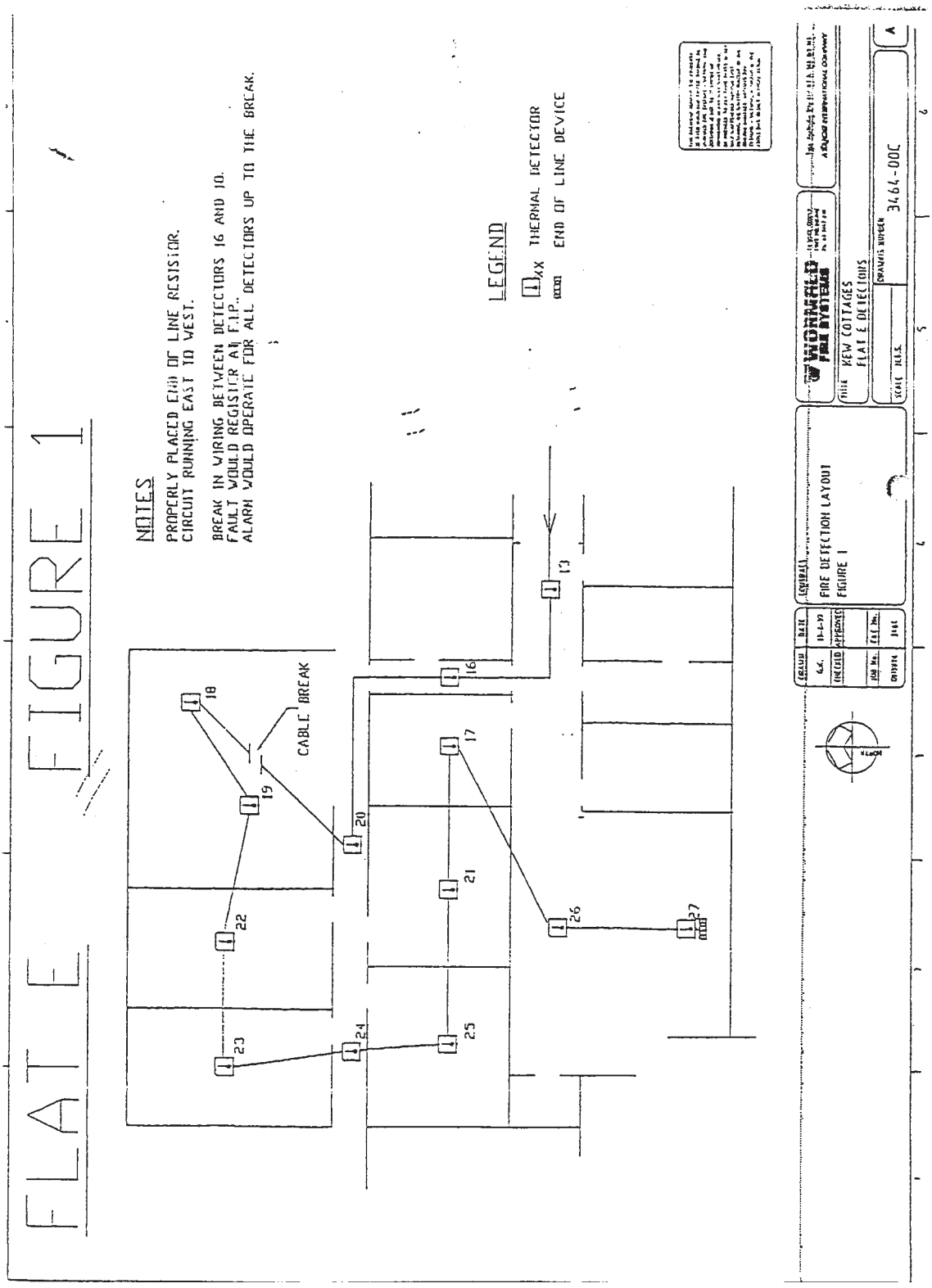
Optical Type: a detector which responds to the scattering or absorbtion of light by smoke particles

* *Letter dated 3-2-97 addressed to the State Coroner and Counsel for parties associated with the Kew Cottages Inquest, from Garry J. Martin, Inspector, Fire Investigation, Metropolitan Fire Brigades Board.*

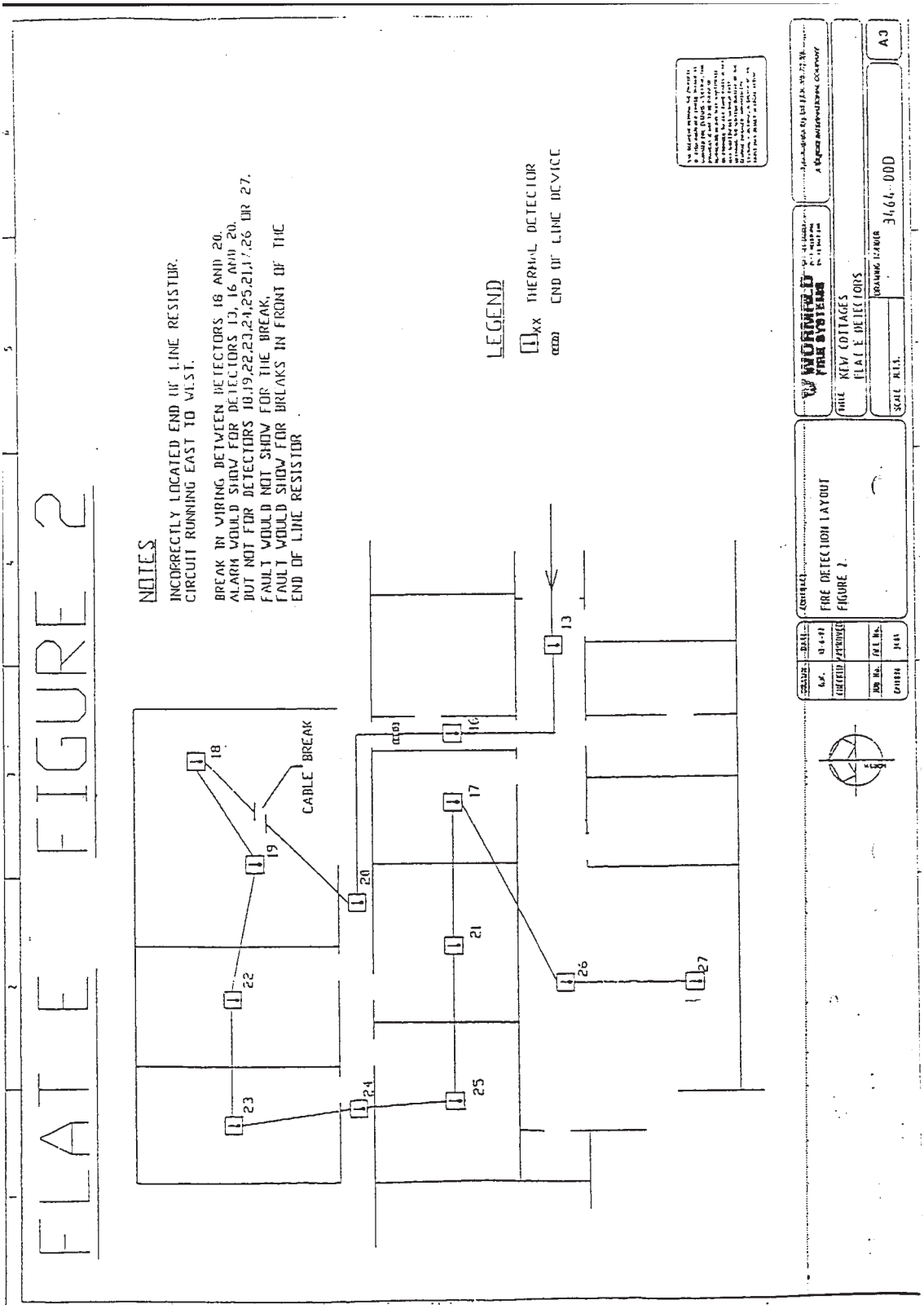
APPENDIX 2.2 THE 'JANUARY PLAN'



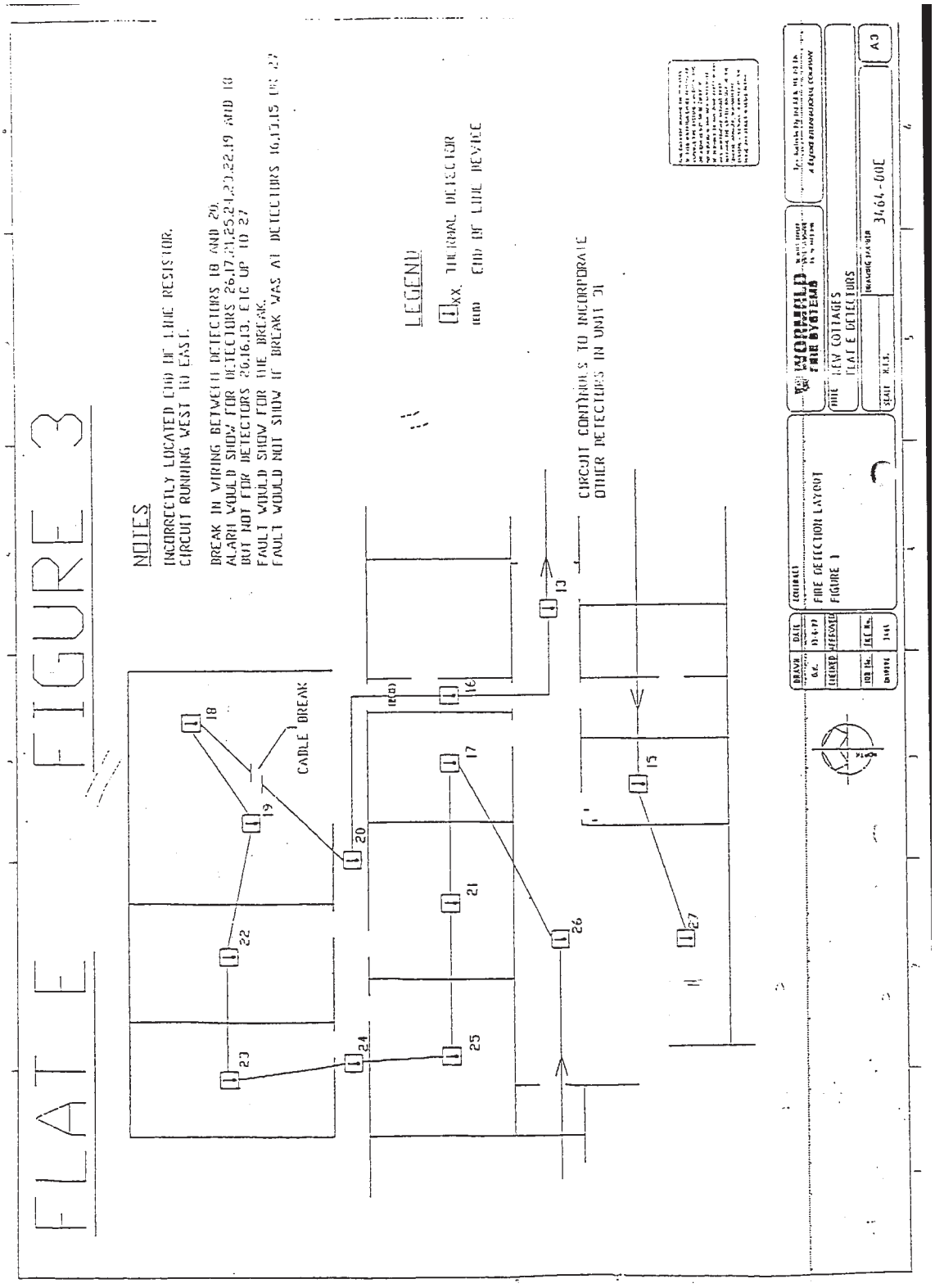
APPENDIX 2.3.1 THE WORMALD 'END OF LINE RESISTOR' PLANS



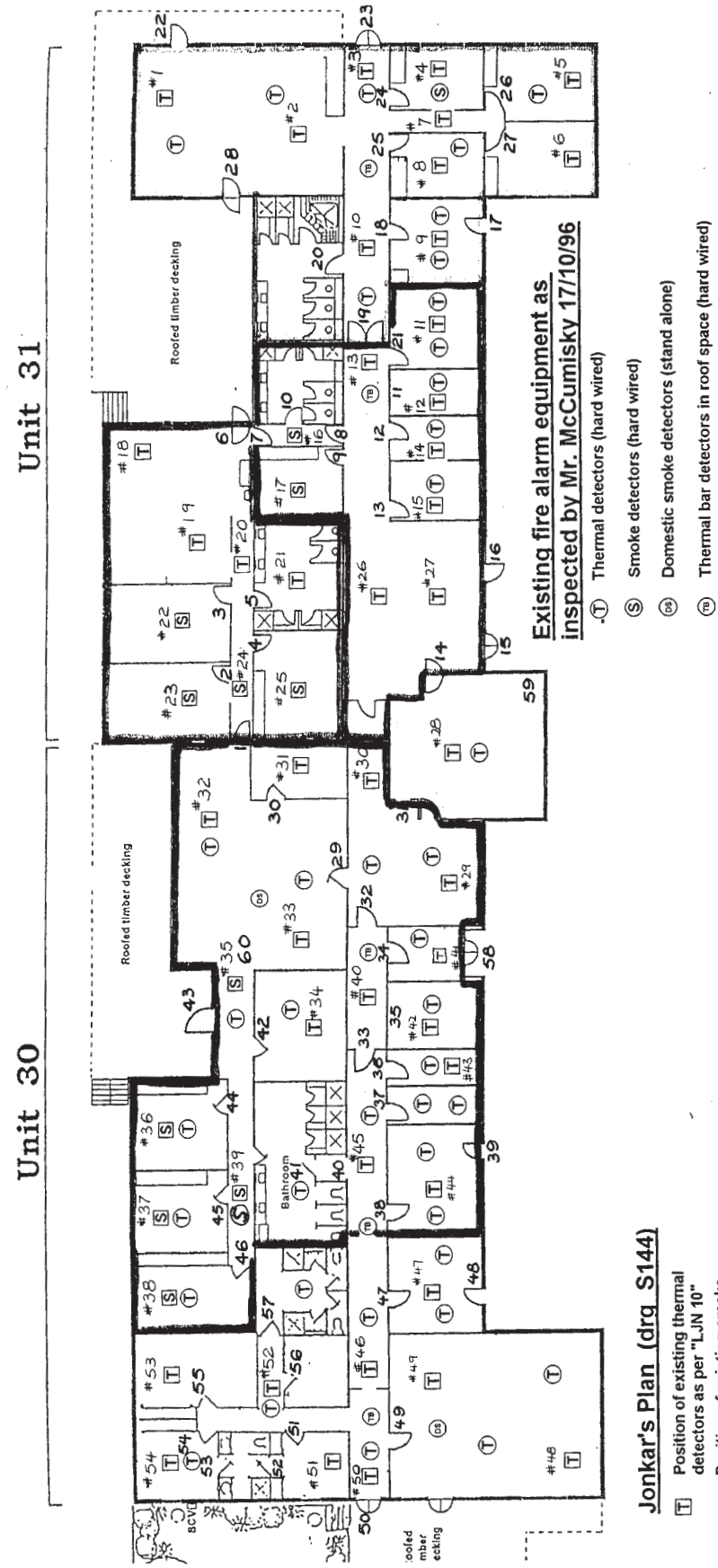
APPENDIX 2.3.2 THE WORMALD 'END OF LINE RESISTOR' PLANS



APPENDIX 2.3.3 THE WORMALD 'END OF LINE RESISTOR' PLANS



APPENDIX 2.4 THE 'McCUMISKY PLAN' (MFB)



APPENDIX 2.5

THE MFB CHRONOLOGY OF EVENTS AT KRS

00/00/65	An MFB officer prepared a comprehensive report on the fire safety of all of Kew Children's Cottages. **(Referred to in Exhibit 171 – the report has not been located)**
00/00/68	An MFB officer prepared a report following up aspects of the 1965 report. By 1972 some of the recommendations had been acted upon, others were awaiting funding. **(Referred to in Exhibit 171 – the report has not been located)**
01/07/68	Six elderly women died at a fire at Willesmere Mental Hospital.
25/11/681	The Coroner delivered his finding into the deaths at the Willsmere Mental Hospital. The Coroner found that the deaths were caused when the bedding of a certified mental patient caught alight when she was smoking in bed. The Chief Fire Protection Officer of the Postmaster General's Department John Snelling and the MFB Assistant Chief Fire Officer William Seabrook called for alarms, sprinklers and staff training. The Chief Fire Protection Officer's report asked that *"serious consideration be given to the protection of all parts of the hospital, where patients are likely to be housed, by automatic sprinklers?.Automatic sprinklers maintain a 24-hour vigil; immediately they are activated by the heat of a fire this causes an alarm to be sounded at the Fire Brigade and commences to discharge water over the fire. Such systems retard the spread of flame, heat and smoke logging."* **(Inquest Transcript -Volume 4 Appendix A of Coroners Brief)**
26/05/69	Superintendent Steel of the MFB, in a report regarding Kew Mental Hospital Senior Section, recommended that "in institutional occupancies where the inmates are not able to help themselves and are under lock and key the only proper protection is a system of automatic sprinklers". **(Exhibit 171)**
15/04/72	District Officer Hunter (MFB) recommended that the only suitable protection for Kew Children's Cottages is the installation of automatic sprinklers. (Exhibit 171)
29/10/75	A painters van was set alight at Kew Cottages – the Police did not reach a conclusion as to who started the fire. Leslie Vincent had just started her employment at Kew Cottages and gave evidence that *"that Paul had been involved or suspected of being involved, generally accepted and known to be involved in the 1975 fire".* There was an Incident Report relating to this incident on Mr Caras' file but it is now missing. **(Exhibit 77, Exhibit 269 – Vincent's statement and Transcript of 10/04/97 Page 6324)**
07/08/79	Station Officer Gray (MFB) recommended in Report No. 79-1895 that there could be a considerable delay in evacuation and that ramps should be installed and exits widened in the four wards where non-ambulatory patients lived (Report No 79 – 1895). **(Exhibit 171)**
30/10/80	The Public Works Department met with the MFB to discuss recommendations in the MFB Report No 79-1895. **(Exhibit 171)**
05/11/80	The Public Works Department wrote to the MFB confirming that the recommendations in Report No 79-1895 regarding Kew Cottages were additional to regulations. They also confirmed that the recommendations flowed from a concern for the type of patient (non- ambulatory) as discussed at the meeting of 30/10/80. **(Exhibit 171)**
15/08/86	Station Officer George (MFB) produced a comprehensive 63 page fire protection report making five main recommendations, including remote control unlocking doors and the upgrade of the existing fire alarm system to Australian standard AS1670. **(Exhibit 171)**
00/09/86 to 00/00/88	Minor works recommended by Station Officer George were completed. **(Exhibit 234 – Taylor's statement)**
08/12/86	John Taylor sent a memo to the Manager of the Property Services Branch of the Department of Community Services regarding a response to SO George's report. **(Exhibit 234 – Taylor's statement)**
08/12/86	The Manager of Kew Cottages Mr W Dobson wrote to the Manager of Property and Services of Community Services Victoria and identified priorities from SO George's recommendations **(Exhibit 234 – Taylor's statement JT1)**

00/00/88	John Taylor prepared a Capital Work Submission for the allocation of funds to upgrade the fire prevention system. **(Exhibit 234 – Taylor's statement)**
11/04/88	The MFB met with the Kew Cottages Acting Manager Daryl Peterson to discuss problems with the fire safety system. **(See note 15/04/88 below)**
13/04/88	The MFB met with Wormalds and the Kew Cottages Acting Manager Daryl Peterson to discuss the fire safety system problems. **(See note 15/04/88 below)**
15/04/88	Senior Technician Bromley of the MFB noted problems identified at meeting with Kew Cottages Acting Manager (Daryl Peterson) on 11/04/88, including the lack of audible fire alarm and the lack of any fire protection in some Units. Bromley noted that at a further meeting on 13/04/88 with Wormalds it was confirmed that Wormalds had forwarded several reports regarding the problems at Kew Cottages to the Public Works Department with no result. **(Exhibit 171)**
18/04/88	Station Officer W Mackwell of the MFB reported on a meeting at Kew Cottages regarding fire safety. He recommended that audible warning systems be installed in each supervisor's office and the that the 1986 MFB report be implemented. **(Exhibit 33)**
30/06/88	The Building Referees Board made a determination allowing egress doors to be locked from the inside at Units 13/14, 17/18 and 19/20 provided that automatic door strike release devices were fitted to the exit ends of the buildings. **(Determination 17314)**
01/08/88	Thos. Walker & Sons were engaged by the Public Works Department – Ministry of Housing & Construction to perform the maintenance of the Fire Alarm at Kew Cottages for $3,168 for the period from 01/07/88 to 30/06/91. **(Exhibit 176 – Vasan's statement SV2)**
03/08/88	Wormalds quoted for the supply and installation of alterations to the fire alarm system in certain buildings at Kew Cottages. **(Exhibit 234 – Taylor's statement JT6)**
13/09/88	John Taylor wrote to the Ministry of Housing & Construction regarding the deficiencies in the existing fire alarm system. **(Exhibit 234 – Taylor's statement JT2)**
00/00/89	John Taylor prepared a Capital Works Submission seeking funds for a major upgrade of the fire protection system. **(Exhibit 234 – Taylor's statement JT9)**
19/01/89	Station Officer Russell reported that a fire in the O'Shea building was of an undetermined cause. He recommended that security be tightened on the inmates and the availability of cigarette lighters and matches restricted. **(Exhibit 171)**
23/01/89	SO Mackwell reported to the Chief Superintendent of Operations that faults with the auxiliary alarms had not been fixed after 9 months and recommendations had not been implemented. The Manager of Kew Cottages told Mackwell that the matter was in the hands of the Public Works Department. **(Exhibit 171)**
20/02/89	John Taylor attended a meeting with senior staff from the Ministry of Housing & Construction to discuss the dissatisfaction with the rate of progress as to addressing MFB recommendations in Report No 86/2214 regarding the upgrade of existing system of fire alarms. **(Exhibit 234 – Taylor's statement JT4)**
23/02/89	John Taylor wrote to all Unit Managers informing them that he would be conducting an audit of all fire protection equipment. **(Exhibit 234 – Taylor's statement JT3)**
23/02/89	John Taylor wrote to the Chief Fire Officer of the MFB (Warburton) regarding his dissatisfaction with the rate of progress of upgrading of the fire alarms as recommended by SO George in 1986. He wrote that the Department of Community Services had requested that the Ministry of Housing & Construction comment on the 1986 report regarding remote-controllable door locks and had had no response. **(Exhibit 234 – Taylor's statement JT4)**
22/03/89	Funds were made available ($16570) for the replacement of the fire indicator panel at the Administration building. **(Exhibit 234 – Taylor's statement JT8)**
02/08/89	John Taylor wrote to the Mr Butler of the Systems Engineering Group of the MFB to invite the MFB to participate in the design of a total fire protection system for Kew Cottages. He stated that he was eager to consolidate these plans so that budget arrangements could be formalised soon. **(Exhibit 234 – Taylor's statement JT10)**

03/08/89	The MFB met with John Taylor to discuss the alarm systems not connected to the MFB and wrote to him about some aspects of cabling. **(Exhibit 234 – Taylor's statement JT11)**
07/08/89	John Taylor wrote to the Manager of Health & General of the Ministry of Housing & Construction expressing great concerns regarding the fire protection services at Kew Cottages. He noted that people were placed at "enormous risk" and that the management at Kew Cottages would not tolerate further procrastination. **(Exhibit 234 – Taylor's statement JT12)**
21/12/89	Peter Haar of the Ministry of Housing & Construction replied to Taylor's letter and notes that funding will be sought through the budget process for emergency lighting and an addressable alarm system. **(Exhibit 234 – Taylor's statement JT14)**
00/04/90	The Department of Management & Budget agreed to allocate $600,000 over 1990/91 to upgrade the fire prevention system, and to allocate $750,000 to upgrade the ring main. John Taylor continued to work on other fire safety issues within the local budget. The funds were not made available during 1990. **(Exhibit 234 – Taylor's statement)**
00/07/90	Srini Vasan commenced at Kew Cottages as the Maintenance Manager. **(Exhibit 176 – Vasan's statement)**
13/07/90	The Deputy State Coroner Johnstone recommended in the Inquest into the fire at Caloola Training Centre in Sunbury that regular reports be undertaken by the CFA into issues including the evacuation of bed-ridden patients and the further consideration of sprinkler systems in priority areas. **(Inquest finding)**
18/07/90	John Taylor wrote to the President of the MFB seeking an exemption from MFB false alarm charges because the age of the system resulted in a number of detector faults. **(Exhibit 234 – Taylor's statement JT17)**
07/10/90	Victor Goh advised Denise Harrison in memo that Paul Caras had a *"History of setting up fire".* In his statement, Goh states that he based this on information he received from older staff and not on any observed incident. **(Exhibit 258.5 – Goh's statement and Exhibit 131B – Goh's memo)**
06/12/90	John Taylor was required to prepare a prioritised list of capital works for the 1991/94 3 year program **(Exhibit 234 – Taylor's statement JT18)**
21/12/90	The client profile of Paul Caras noted *"SETS FIRES – ABSCONDS".* This note stayed on his profile and was printed out again on 02/01/91. **(Exhibit 131A)**
07/02/91	John Taylor forwarded a list of major capital works priorities for 1991-4 to the Works & Property Manager. The first item listed in order of priority was *"Upgrading fire protection system – $790 000"*. No funds were provided. **(Exhibit 234 – Taylor's statement JT19)**
09/08/91	Jonkars Pty Ltd were engaged for a period from 01/07/91 to 30/06/92 at a tender price of $3,500. They were required to maintain the fire protection system at Kew Cottages, carry out annual testing of detectors and monthly testing of indicator lights on the new alarm panel and to respond to false alarms, 24 hours a day, 7 days a week. All work was to be carried out to the satisfaction of Public Works and the testing and the maintenance of the log book was to be in accordance with Australian Standards AS1670-1983 and AS1851-1986. **(Exhibit 193 – L Neicho's statement LJN1)**
Mid/08/91	Once engaged, Jonkars conducted a full inspection and test of the fire protection system. Kristine Talbot prepared plans of the layout of detectors. Unit 30/31 contained Olsen thermal detectors and three were found not to operate. **(Exhibit 193 – L Neicho's statement and LJN20)**
03/09/91	Victor Goh prepared the 1991 Annual Nursing Review of Paul Caras and noted that: *"Has the history of setting fire when he has the opportunity of possessing fire lighter*." **(Exhibit 131B)**
14/11/91	Jonkars (Talbot) repaired a BGA and replaced three defective heat detectors in Unit 30/31 and noted this in Service & Field Instruction 0274. **(Exhibit 193 – L Neicho's statement and LJN21)**
11/12/91	Jonkars (Talbot) replaced a faulty BGA in Unit 30/31 and noted this in Service and Field Instruction 0297. **(Exhibit 193 – L Neicho's statement and LJN21)**
24/12/91	John Taylor wrote to the Regional Resource Manager, Inner East to seek funding for Major Capital Works for 1992-1995. The first priority was the *"Upgrade fire protection system $850 000"*. **(Exhibit 234 – Taylor's statement JT20)**

00/00/91	The Annual Report of Community Visitors pursuant to the Health Services Act 1988 noted that client smoking in bed was a serious cause of fire hazard and recommended that the Department consult with the fire authorities about the necessary measures for fire safety. **(Coroner's Brief Volume 4)**
00/00/91 to 00/00/92	Bedroom partitions installed in dormitories in Unit 30/31. **(Exhibit 58 – McCartin's statement FPM10)**
Late/91	Leslie Neicho of Jonkars prepared detailed plans of circuit 39 and 40 in Unit's 30/31 on the basis of Talbot's plans. **(Exhibit 193 – L Neicho's statement and LJN8)**
28/01/92	Bradney Edgar wrote to the Department of Planning & Development asking them to engage Steeves Lumley to undertake a risk management survey for a number of training centres, including Kew. **(Exhibit 262 Edgar's statement)**
29/01/92	Bradney Edgar of the Department of Community Services issued a memo to all regional resource managers regarding fire safety in community based residential facilities. It noted that smoke alarms must be installed during the course of *"major building alterations/additions....the requirement is binding on the Crown...that although the installation of 9 volt battery operated smoke alarms is the minimum requirement for residential buildings undergoing major alterations/ additions, a 240 v mains system requires less maintenance and is regarded as more reliable."* **(Exhibit 239)**
01/05/92	John Taylor was advised by the management of Community Services Victoria that the upgrade of ring main ($800 000) and fire protection system ($850 000) were included as CSV capital works priorities for 1992/5 for the purposes of Treasury budget submissions. No funds were provided prior to the change of government. **(Exhibit 234 – Taylor's statement JTN21)**
Mid/92	Taylor re-activated the Fire Committee and it met regularly until July 1993. **(Exhibit 234 – Taylor's statement)**
18/06/92	The Director of Industrial Relations & Workcare, Laurie Bebbington of the Department of Community Services sent a memo to all Regional Directors, Regional Managers and CEO's and noted that *"Statistics prove that the majority of fires between 2am and 5am are caused by smoke asphyxiation. Early smoke detection is essential to avoid serious injury and death..."*. The memo noted that the departmental policy of Community Services was that only mains wired smoke detectors with a battery back-up be installed as clients may remove batteries from battery operated detectors. **(Exhibit 240)**
02/07/92	Steeves Lumley Limited conducted a risk management survey at Kew Cottages and were assisted by Taylor and Vasan. They held a walk through inspection and performed random sampling. The survey noted that current testing of detectors was not monitored and recommended upgrading the thermal alarm system to current technology, reviewing the service contract to ensure it complied with AS1851.8 and developing a new fire manual. **(Exhibit 53 – Lumley Report)**
08/07/92	Deputy State Coroner Wilmoth recommended in the Inquest into the death of four elderly residents of Leige Court Special Accommodation Centre that residential sprinkler systems be made mandatory in all supported residential services, especially in view of the view of ten deaths in such services in nine months, the reduced mobility and independence of elderly residents and the difficulty of evacuating such residents with currently accepted staff ratios. Thus: *" The ability of a sprinkler system to put out a fire (even though this cannot be guaranteed) cannot be bettered by any other available system on a premises and might obviate the need for evacuation, or at least reduce the urgency, and so save residents from both smoke and flame".* **(Inquest finding – Case numbers 1231,1233, 1242,1244/91)**
08/07/92	Deputy State Coroner Wilmoth recommended in the Inquest into the deaths of six residents of the Athol Lodge Special Accommodation House in the same terms as in the Leige Court Inquest. **(Inquest finding – Case numbers 292/92, 4282/91, 54/92, 71/92 and 70/92)**
13/07/92	Deputy State Coroner Wilmoth recommended in the Inquest into the fire at St Kilda Town Hall that a sprinkler system be fitted. **(Inquest finding – Case number 11331/91)**
16/07/92	Kew Cottages/Parents Association Liaison Meeting 6/92. A Parent's Association representative raised the issue of sprinklers after recent media reports and asked whether dependant units have such a system. The meeting agreed that this should be followed up as a priority. **(Exhibit 233)**

17/07/92	Jonkars were engaged by the Ministry of Housing & Construction for the fire protection maintenance contract for Kew Cottages for the period 01/07/92 to 30/06/93 for the sum of $3500. The letter accepting Jonkar's tender lists R L Stewart as the *"Work Manager "* and notes that *"All work must be carried out to the satisfaction of the Superintending Officer of this Ministry".* **(Exhibit 176 – Vasan's statement SV2)**
00/07/92 to 00/06/93	Jonkars carried out annual tests of the fire protection systems and tested each detector. Les Neicho prepared a report regarding the testing. **(Exhibit 193 – L Neicho's statement and LJN14)**
14/08/92	Kew Cottages/Parents Association Liaison Meeting. The minutes recorded that John Taylor was to be asked for further advice about the sprinkler system. John Taylor reported that the fire committee had been reinvigorated and a Fire Awareness Day would be held later that year. **(Exhibit 233)**
10/09/92	Kew Cottages/Parents Association Liaison Meeting. The minutes recorded that Margaret Jackson, the CEO of Kew Cottages reported on the attempts to get funding for a total upgrade of the fire safety system. John Taylor reported that the Fire Committee was currently addressing the issue of sprinklers and had approved a number of smoke detectors. **(Exhibit 233)**
19/11/92	Jonkars attended at Unit 12 to find 2 damaged detectors, replaced them and noted this in Service and Field Instruction 2705. **(Exhibit 227 – Stewart's file)**
09/12/92	Jonkars (S Moore) attended circuit 51 to find 2 broken BGA glasses, replaced them and noted this in Service and Field Instruction 0321. **(Exhibit 227 – Stewart's file)**
Late/92	Community Services Victoria and the Department of Health merged to form Health & Community Services. Taylor understood that funding for the fire prevention upgrade was made available. **(Exhibit 234 – Taylor's statement)**
00/00/92	The Annual Report of Community Visitors noted serious fire problems in supported residential units and supported the State Coroners' call for the mandatory installation of residential sprinkler systems. **(Coroner's Brief Volume 4)**
00/02/93	The Department of Planning & Development were engaged by the Community Services Victoria to complete a review of emergency services at Kew and other sites. The project manager appointed by the Department of Planning & Development was John Dibben.. **(Exhibit 262 – Edgar's statement)**
25/02/93	Kew Cottages/Parents Association Liaison Meeting. John Taylor was present. The minutes recorded that John Malloy from the Parents Association raised a query about the need for smoke alarms and sprinkler systems in dependant units and that *"smoke alarms were to be placed in every unit at the Cottages this financial year and that there was a current project group auditing all institutions to determine what fire protection system should be in place."* **(Exhibit 233)**
00/03/93	John Taylor pursued the idea of interim solutions for the fire protection system. In particular he responded to the advice of the MFB comments about the lack of local alarms. He consulted Daryl Knight and Wormalds about local alarms. Daryl Knight suggested that a full fire audit was necessary but Taylor perceived that John Dibben would be appointed for that role. Wormalds suggested a system but warned that it would not comply with standards. As a result, Taylor did not think it would be appropriate to pursue this. Taylor approached Denise Harrison with his concerns and as a result a permanent staff member was appointed to monitor the fire indicator panel at night and inform the staff in Units of alarms. The AHCOT staff were also supplied with mobile phones. Taylor gave evidence that he believed the issue of local alarms was delayed because Dibben was not appointed to perform the fire audit, as Taylor assumed he would be. **(Transcript 19 March 1997 , Pages 5197-5208 – Evidence of John Taylor)**
Early/93	Jonkars attended the Avenue Hostel to find a damaged underfloor detector . They replaced the detector and noted it in Service & Field Instruction 0558. **(Exhibit 227 – Stewart's file)**
Early/93	Jonkars attended the pharmacy to remove a BGA that was activating due to continual breaking by person unknown. They noted this in Service & Field Instruction 0395. **(Exhibit 227 – Stewart's file)**
04/03/93	The Manager of Capital Works of Health & Community Services wrote to Taylor and invited him to supply the capital work priorities for Kew. **(Exhibit 234 – Taylor's statement and JT22)**

15/03/93	John Taylor submitted his Major Capital Works Priorities for 1993/4 and again lists as the number one priority *"Upgrade Fire Protection System $850 000".* **(Exhibit 234 – Taylor's statement and JT23)**
22/03/93	In response to John Taylor's request, Ken Howie from Wormald provided him with a quotation for an interim local alarm system for $8629 with no battery back up. **(Exhibit 174 & Exhibit 234 – Taylor's statement)**
23/03/93	In response to John Taylor's request, Daryl Knight sent a memo to Wormalds regarding his suggestion for a local alarm system for Kew Cottages. **(Exhibit 212 – Knight's statement)**
26/03/93	Wormalds quoted $28,588 for the installation of 185 combustion detectors and an indicator board. **(Exhibit 176 – Vasan's statement – SV7)**
00/04/93	As a result of state wide directive regarding smoke detectors, John Taylor ordered installation of same. Fire Fighting Enterprises installed 235 hard wired smoke detectors linked to the existing system, including 5 in Unit 30/31. **(Exhibit 176 – Vasan's statement SV4)**
15/04/93	There was a fire in Unit 19 apparently caused by a washing machine. The thermal detector did not activate. Les Neicho of Jonkars tested the detector shortly after and found no fault. Station Officer McCarthy of the MFB reported on the incident on 15/04/93 and noted that a number of the exit doors fitted with automatic unlocking mechanisms were not connected to manual fail safe device or the automatic unlocking devices in case of an emergency. He noted that at night the patient/staff ratio was such that an evacuation might be delayed. A copy of his report was provided to John Taylor. **(Exhibit 171).**
22/04/93	Jonkars (K Talbot) attended the Hamer Centre to find a broken thermal base. They replaced it and noted it in Service & Field Instruction 0652. **(Exhibit 227 – Stewart's file)**
00/05/93 to 00/06/93	John Dibben approached Norm Winn of Norm Winn & Associates and George Newton of Corporate Emergency Planning (Aust) and asked them to submit a proposal to undertake a fire protection survey of various government sites including Kew Cottages. Winn & Newton's proposal was accepted by Dibben and they begun work in July 1993. **(Winn's statement)**
13/05/93	Kew Cottages/Parents Association Liaison Meeting. John Taylor was present. The minutes recorded that *"Issue of safety given the new partitions and the installation of sprinkler systems in dependant Units was raised. Will be reviewed by Project Group for next year's Works Program. Smoke detectors are now installed in units."***(Exhibit 233)**
29/05/93	SO Mackwell of the MFB attended the Hamer Wing to find a broken BGA. **(Exhibit 57 – Report 69904)**
10/06/93	False alarm at 1055 hrs in Unit 30 or 31. Workers set off detector. **(Exhibit 57 – Report 69907)**
11/06/93	False alarm at 1208 hrs on circuit 39 in Unit 30 or 31. Dust set off a smoke detector. **(Exhibit 57 – Report 69909)**
18/06/93	False alarm at 835 hrs on circuit 39 or 40 in Unit 30 or 31. There were workers in the area near "39/40" near door 33. **(Exhibit 57 – Report 69920)**
22/06/93	False alarm at 933 hrs in Unit 30/31. MFB Report noted that a smoke detector was activated. **(Exhibit 57 – Report 69924)**
26/06/93	SO Kelly of the MFB attended the Hamer Wing to find 2 broken BGA's. **(Exhibit 57 – Report 69929)**
04/07/93	SO Kelly of the MFB attended the Hamer Wing to find a broken BGA. **Exhibit 57 – Report 69936)**
12/07/93	Audit inspection conducted by John Dibben, Norm Winn, George Newton and John Seedsman – the Project Officer from the Department of Health and Community Services. They were accompanied by John Taylor and Srini Vasan. **(Exhibit 54 – Dibben Report)**
15/07/93	Jonkars attended Unit 30 and Stephen Moore replaced a missing smoke detector head over a bed. He cannot remember the room. **(Exhibit 185 – Moore's statement and Service & Field Instruction 0703)**
18/07/93	False alarm at 1807 hrs caused by heat from cooking setting off a thermal detector in either Unit 30 or 31. **(Exhibit 57 – Report 69938).**

23/07/93	State Coroner West noted in the Inquest into the fire at the Ministry Flats in Carlton that the MFB had raised concerns about the ramifications of the possible entrapment of persons in enclosed balconies and accordingly had recommended the installation of residential sprinkler systems. State Coroner recommended that the MFB and the Ministry of Housing should continue to liaise over the MFB's issues of concern with the aim of ensuring the safety of tenants and others on such premises. **(Inquest finding – 2339/92)**
24/07/93	False alarm at 1142 hrs in Unit 30 or 31. There were renovation works occurring at the time. **(Exhibit 57 – Report 56036)**
25/07/93	Station Officer Stewart of the MFB attended to find a broken BGA in an unspecified Unit. **(Exhibit 57 – Report 5307)**
26/07/93	False alarm at 1514 hrs on Circuit 40 in either Unit 30 or 31. **(Exhibit 57 – Report 69948)**.
00/07/93 to 00/07/94	Jonkars carried out annual tests and inspection of fire protection systems (including each detector) – Leslie Neicho prepared a report regarding each detector. **(Exhibit 193 – Les Neicho's statement LJN15)**
00/07/93	The Kew Cottages Fire Safety Committee met for the last time. Three of the members of the Committee were unable to continue their participation. Vasan continued to work on fire prevention issues. **(Exhibit 176 – Vasan's statement paragraph 6)**
00/07 – 00/08/93	Jonkar installed ten smoke detectors and one thermal detector in the area now referred to as Flat E. Vasan states the work was completed at this time. Moore says the work was completed in about September 1993 (see below) **(Exhibit 176 – Vasan's statement and SV11 and Exhibit 185 – Moore's statement as amended)**
00/08/93	John Dibben completed his report and provided it to Bradney Edgar at Health & Community Services. Edgar was no longer responsible for the project and his responsibility was handed over to Emanuel Savona. The report criticised the fire protection system and evacuation system and recommended the installation of sprinklers. The report was never provided to John Taylor or Srini Vasan. **(Exhibit 54 – Dibben report and Exhibit 262 Edgar's statement)**
18/08/93	Station Officer Goddard of the MFB attended Unit 4 and found a BGA that had been broken by a client. **(Exhibit 57 – Report 56327)**
30/08/93	James Fox of the Office of Building met with John Taylor. Taylor told Fox that Kew Cottages would not be needing the services of the Office of Building generally at Kew Cottages as they had the in-house expertise and that they had an engineer employed. **(Fox's statement)**
00/09/93	Renovations were carried out in the areas that became Flat E with the addition of this area. Units 30 and 31 at this time comprised of an "H" shaped block with the beds in dormitories at the eastern and western ends of the building. The internal area had comprised of bathrooms and living room areas as shown in the map creaetd by Lesley Vincent in March 1993. The two unit structure was retained. Clients were moved out of this unit whilst these works were completed. **(Exhibit 274 – Vincent's map, Exhibit 193 – LJN6, Transcript of 3 March 1997 Page 4418-9, Transcript of 15 April 1997 Page 6112 and Transcript of 10 April 1997 Page 6321)**
02/09/93	False alarm at 1025 hrs in Unit 30 or 31 caused by workers digging in concrete floor. **(Exhibit 57 – Report 56342)**
03/09/93	Jonkars were called to a false alarm in Unit 30 or 31. Stephen Moore attended and has given evidence that he cannot recall the incident. The Service & Field Instruction records that the false alarm was caused by dust in the detector. Moore gave evidence that he would not have changed the detector as the Service & Field Instruction does not record any such change. He gave evidence that *"...if I changed a thermal detector or a smoke detector to the opposite, smoke to thermal, thermal to smoke, in my docket – it's just standard practice to make a note of it on the docket.*" **(Exhibit 193 – L Neicho's statement LJN22 and Inquest Transcript of 21/02/97 Page 4044-5 – Stephen Moore's evidence)**
03/09/93	The Department of Health & Community Services ordered smoke detectors from Jonkars including 10 smoke detectors for the area that became Flat E. Order no. 255836 specified $900 for upgrade fire alarm system in Unit 31 extension. A subsequent invoice no 243255 dated 01/12/93 (which is out of number order) specified the same amount for same work. The work was carried out in September 1993. **(Exhibit 176 – Vasan's statement SV11 and Exhibit 193 – L Neicho's statement LJN23 and LJN26)**

29/09/93	Jonkars prepared a quotation sheet ($1,695) for the installation of 10 smoke detectors in Unit 30/31. **(Exhibit 193 – L Neicho's statement LJN23).**
Late/09/93	Vasan directed Jonkars to install smoke alarms at Kew Cottages, following the statewide directive (Order no 255836). Stephen Moore installed 10 Hochiki smoke detectors in the area that became Flat E of Unit 31 although he cannot recall doing this. At that time, the Flat E area comprised of bedrooms and the kitchen/living area was 2 bedrooms, whilst the bathroom was also a bedroom There was one thermal detector installed in the corridor of what became Flat D (near doors 24 to 27). Stephen Moore prepared a handwritten plan which showed seven smoke detectors in the bedrooms of the area that became Flat E, two smoke detectors in the corridor and one smoke detector in the corridor of what became Flats C and E. The work was invoiced on 29/12/93. **(Exhibit 176 – Vasan's statement SV11, Exhibit 185 – Moore's statement and Exhibit 193 – Neicho's statement LJN25)**
08/10/93	Jonkars (S Neicho) attended Unit 7-8 and found 2 damaged bar detectors. These were replaced and noted in Service & Field Instruction 0753. **(Exhibit 227 – Stewart's file)**
08/11/93	Station Officer Moore of the MFB attended the pool/physio and found a broken BGA. **(Exhibit 57)**
14/11/93	Station Officer Kelly of the MFB attended the pool/physio and found a broken BGA. **(Exhibit 57 – Report 73457)**
14/11/93	Station Officer Barnes of the MFB attended the pool/physio to find a broken BGA. **(Exhibit 57 – Report 73458)**
25/11/93	Emanuel Savona and David Hughes of the Capital Management Branch met with John Taylor and Denise Harrison to discuss a Fire Safety Upgrade. It had been decided that the Capital Management Branch of the Department of Health and Community Services would conduct a fire prevention audit and upgrade, under the control of Emanuel Savona. He directed the formation of a Project Control Group to oversee the tendering process for the audit and the work. Discussions and meetings commenced and Savona requested information from Taylor.**(Exhibit 214 – Savona's statement)**
28/11/93	SO Cass of the MFB attended the pool/physio to find a broken BGA **(Exhibit 57 – Report 73464)**
Late/93	Norm Winn of Norm Winn & Associates Pty Ltd spent three full working days at Kew Cottages extensively examining the premises. He quotes Srini Vasan specifically expressed his concerns about staffing levels at night and this combined with their lack of training would provide difficulty in effecting evacuation of residents in emergency. **(Winn's statement)**
00/12/93	Taylor and Vasan obtained further quotations regarding the local alarm panel. They do not proceed further because of the decision by Capital Management Branch to fund a comprehensive upgrade. **(Exhibit 176 – Vasan's statement)**
00/12/93	Taylor reviewed the fire protection equipment at Kew Cottages and prepared a list for all buildings. **(Exhibit 234 – Taylor's statement – JT25)**
08/12/93	The contract for E G O'Flynn to build 3 bedrooms and the pergola in the area that was to become Flat B was approved. **(Transcript of 3 April 1997 Page 5976)**
Mid/12/93 to 00/03-05 /94	The area that was to become Flat B of Unit 30 was renovated with the addition of 3 bedrooms and a pergola. These renovations were completed at about the same time as the Flat A renovations in April/May 1994 or a little earlier. **(Transcript of 3 March 1997 Page 4418-9, Transcript of 3 April 1997 Page 5976 and Transcript of 8 April 1993 Page 6113)**
16/12/93	John Taylor wrote to Savona providing information about Kew Cottages and noting that *"Kew Cottages will in the main, be dependant on your recommendations around the total system".* Taylor noted that Kew Cottages wished to introduce *"additional interim protection equipment pending the commissioning of the new system".* He gave evidence that *"towards the end of 93 we again started to generate – I asked Mr Vasan if he would get some quotes on – further quotes – on local alarms, local bells, and prior to us doing anything in that regard once we got those quotes, Capital Management was on site and they were saying, they were assuming control of the project and we again put it to them that, as in this letter, which we have just looked at, I put it to Mr Vasan that he should again concern himself with some local warning bells."* **(Exhibit 172 and Evidence of John Taylor on 19 March 1997 Page 5206-7)**

23/12/93	Wormalds provided a further quotation for local alarm bells with an additional $3900 for battery back up. **(Exhibit 174 and Exhibit 234 – Taylor's statement)**
00/00/93	The Annual Report of Community Visitors noted that client smoking in bed was a still a serious concern. A special "Fire Risk Assessment Unit" had been examined the issue of fire safety in supported residential services and the report noted that with regard to the unit's recommendations, a game of "pass the parcel" was occurring between government departments. **(Coroner's Brief Volume 4)**
05/01/94	False alarm at 1107 hrs in Unit 30 or 31. MFB Report 66419 recorded that a smoke detector was activated due to dust. **(Exhibit 19)**
14/01/94	False alarm at 836 hrs in Unit 30 or 31. MFB Report 66430 recorded that a smoke detector was activated due to dust. **(Exhibit 19).**
20/01/94	False alarm at 1610 hrs in Unit 30. MFB Report 76725 recorded that a detector on Circuit 39 was activated and that " Workmen in Unit 31 which is under renovation, may be the cause." Jonkars attended and Stephen Moore noted on Service & Field Instruction 0527 that he attended Unit 30 and he "located smoke detector in alarm due to dust caused by contractors, replaced smoke with thermal detector until contractors work finishes.". Stephen Moore gave evidence that he thought that he replaced the smoke detector in the area that became Flat B, but he was not entirely sure of this. He gave evidence as follows: *"Now, where did you find this – are you able – and I don't want you to guess about this, but do you recall where the smoke detector was in the one that you refer to in Paragraph 12; you do say in relation to both those attendances that you don't recall the attendances? —That's correct, and I couldn't a hundred per cent verify which detector it was..... Is it your belief that these detectors were in the area known as Flat B?—Yes, that is my belief.* *Why do you have that belief?—I have that belief, because that is where the contractors were working."* There is not record of a smoke detector being reinstalled. **(Exhibit 57, Exhibit 193 – L Neicho's statement LJN21, Exhibit 185 – Moore's statement and Transcript of 21 February 1997 Page 4020)**
21/01/94	Vasan wrote a memo to Savona telling him that due to *"the lack of local warnings and delay due to the extent of site/location of buildings and staff numbers, replacement or modification to the existing system has become our top priority."* He asked him to include into the fire safety audit brief a requirement for a recommendation to an appropriate fire safety system. **(Exhibit 173)**
26/01/94	False alarm at 835 hrs in Unit 30 or 31. MFB Report 76733 noted that there were building renovations in Unit 30. Jonkars attended and Stephen Moore noted in Service & Field Instruction 0531 that he found one of the smoke detectors in Unit 30 in alarm. He replaced five smoke detectors in the area that became Flat B with thermal detectors. The Service & Field Instruction indicated that the smoke detectors were to be reinstalled when the work had finished but there is no evidence that this was done. **(Exhibit 57, Exhibit 193 – L Neicho's statement LJN21, Exhibit 185 – Moore's statement and Transcript of 21 February 1997 Page 4020)**
29/01/94	Advertisements appeared in newspapers for expressions of interest for consultants for the upgrade project. The close of submissions was 04/02/94. **(Exhibit 214 – Savona's statement)**
00/02/94 to 00/03/94	S Moore assisted with installation of 5 smoke detectors in Flat B of Unit 30 – 1 in each of the 3 bedrooms and 2 in corridor outside the bedrooms (detectors 39-35 to 39-39). **(Exhibit 185 – Moore's statement as amended)**
15/02/94	The Department of Health & Community Services paid Jonkars $1800 re. invoice's 001392 and 001393 for the area that became Flat E. **(Exhibit 176 – Vasan's statement and SV11)**
23/02/94	ULA were provided with the Consultants Brief entitled *"Fire Safety Upgrade – Consultant Brief Fire Audit and Schematic design".* The letter from the Department of Health & Community Services invited ULA to submit a final submission in anticipation of an interview on 10/03/94. **(Exhibit 169 – Lai's file Page 160-164)**
10/03/94	Emanuel Savona, John Taylor and Srini Vasan interviewed ULA, Knight and other shortlisted consultants for the Kew Training Centre Fire Services Upgrade consultancy. Dominic Lai's notes show that the Dibben report was mentioned. The question of Interim systems was raised and John Taylor gave evidence as follows: *"Are you able to recall precisely what each applicant*

	consultant was asked in relation to the question of interim solutions?—We outlined to each applicant that we had a – our current system which did not have a local warning system and asked them what interim measure could be – did they have in mind, or could they recommend, a local warning system that could be put in place prior to the upgrade. *Yes?—Some of them were coy about offering their suggestions in terms of us getting free advice, others were quite forthcoming in what they might do....* *Could you look at para.12 of Mr Lai's re-examination; I won't read it, Your Worship, I think that is time consuming, but it concerns what Mr Lai says was raised at that initial interview and in substance Mr Lai says, and he has given evidence to this effect, that he attended the interview with Mr Johnston of SSL and that you raised the possibility of installing local alarms in buildings without fire bells; what do you say as to that; did you say something along those lines?—We said that to all the applicants.* **(Exhibit 241, 242 – notes of interviews, Exhibit 169 – Lai's file Page 159 and Transcript of 19 March – Taylor's evidence Page 5218-9)**
16/03/94	ULA were appointed as the consultants for the KRS Fire Services Upgrade at about this date. There was no written contract. **(Exhibit 214 – Savona's statement)**
16/03/94	Taylor and Vasan met with ULA to discuss interim measures and a local alarm system. Dominic Lai asked Russell Cooper to investigate a low cost interim measure and Cooper advised Lai that this was not possible. Lai advised Taylor accordingly. **(Transcript of 19 March 1997 – Taylor's evidence- Page 5220, 5223)**
00/04/94 to 00/05/94	Renovations were conducted in the area of Unit 30 which became Flat A. **(Transcript of 3 April 1997 Page 5976 and Transcript of 8 April 1997 Page 6113)**
02/04/94	False alarm at 1247 hrs. SO Kelly completed MFB Report 79550 and noted that *"Smoke from BBQ set off smoke detector in Unit 31". Kelly gave evidence as follows: "This was a barbecue on the decking outside Flat B, is that so? —That would be correct.* *I'm sorry, could you just point on the map please to where you believe the smoke detector was?—Approximately around where the A is there.* *You are suggesting your recollection is there was a smoke detector in the corridor of Flat B?—That is correct."* **(Exhibit 57 and Evidence of Kelly on 21 October 1996 at Page 455)**
07/04/94	Lesley Vincent put in a request to John Taylor and Srini Vasan for a local alarm bell in Unit 31. **(Exhibit 275)**
12/04/94	Alan Clayton, the Director of Resources of the Department of Health & Community Services sent an Information Circular entitled "Smoke and Electrical Protection for Existing Buildings". It recommended the progressive installation of hard wired smoke detectors and the replacement of thermal detectors with same. It stressed the need for adequate maintenance and a maintenance schedule and noted that the Department of Health & Community Services *"acknowledges that smoke detectors and earth leakage devices will enhance the fire safety of existing buildings.* It recorded that *"There is a widespread recognition that smoke alarms can save lives. They give the earliest warning of a fire and allow precious time to either extinguish the fire or evacuate the occupants."* **(Exhibit 238)**
16/04/94	SO Brown of the MFB attended Kew to find a broken BGA at an unspecified Unit. **(Exhibit 57 – Report 78608)**
26/04/94	SO Kelly of the MFB attended Unit 10 to find a broken BGA. **(Exhibit 57 – Report 78617)**
00/05/94 to 00/06/94	ULA/SSL carried out the fire safety audit at the Kew Training Centre. Shortly prior to carrying out the audit Lai asked Cooper of SSL to recommend any low cost interim measures. Cooper considered low energy sounders and interconnected stand alone smoke alarms which he rejected because he perceived the noise would be distressing to clients. Cooper gave evidence that he held this perception because of discussions with Department staff, perhaps at another job at Kew Cottages. **(Exhibit 142 – Lai's statement, Exhibit 249 – Cooper's statement and transcript of 26 March 1997 page 5612)**
03/05/94	Dominic Lai attended a Fire Safety Audit Meeting at Kew. He noted on his copy of the agenda next to Item 3 *"build in interim solutions"*. Mr Lai gave evidence when questioned as follows: *"And one of the things you put in there, I suggest, is "*3) Discuss immediate work regarding inter-unit communication". See Item 3 on p.156?—Yes, I did.

	Is that something you had already had raised with you by Kew, by the Department?—Yes. That that was something they wanted you to look at?—Yes. *Inter-unit communications. What do we take that as, Mr Lai? —The ability for an adjacent unit to find out what happened to units in danger, or what we now call the buddy system.* *That looks awfully to me, and I'll ask you to comment, like an interim issue that you were being asked to consider. "Discuss immediate work regarding inter-unit communication". Doesn't it have that flavour about it? —Yes.* **(Exhibit 169 – Lai's file Page 156 and Evidence of Dominic Lai 7 January 1997 Page 3497-8)**
05/05/94	SO Goddard of MFB attended Unit 10 to find broken BGA. **(Exhibit 57 – Report 78623)**
07/05/94	SO Sweeney of MFB attended Unit 10 to find broken BGA. **(Exhibit 57 – Report 78623) .**
10/05/94	Dominic Lai attended a Fire Safety Audit Meeting with Kew Training Centre staff. He prepared an agenda which referred to a MFB Report and a previous audit report . **(Exhibit 169 – Lai's file Page 155)").**
16/05/94	ULA/SSL carried out an inspection of all Units and Lai noted observations. **(Exhibit 169 – Lai's file Page 145-154)**
16/05/94	SO Goddard of the MFB attended the Pool/Physio complex to find a broken BGA. (Exhibit 57 – Report 78631)
21/05/94	SO Goddard of the MFB attended Unit 10 to find a broken BGA. **(Exhibit 57 – Report 78636)**
Mid/94	Kew Training Centre proposed to continue with introducing smoke alarms and ULA advised against this because it is ad hoc. In Vasan's statement he states that Kew proposed to introduce smoke detectors but Lai gave evidence that this issue was in relation to smoke alarms. **(Exhibit 176 – Vasan's statement and Evidence of Lai on 4 February 1997 – Page 3269-70)**
01/06/94	ULA/SSL conducted an observed and unannounced fire safety drill at Unit 7/8 and identified a number of deficiencies. Peter Johnson prepared a summary of the drill. **(Exhibit 169 – Lai's file Pages 130-133)**
08/06/94	Taylor wrote to ULA and advised them that they had been successful in their application for the consultancy with an immediate start and work completed by 30 June 1994. **(Exhibit 169 – Lai's file Page 128)**
29/06/94	First Meeting of the Project Control Group Meeting. Members were John Taylor, Wayne Dobson, Srini Vasan, Manny Savona, Dominic Lai, Russell Cooper and Graham Tims. **(Exhibit 169 – Lai's file Page 127)**
00/07/94 to 00/12/95	Jonkars carried out the annual tests and inspection of the fire protection systems and each detector at Kew Training Centre. **(Exhibit 193 – Neicho's statement LJN16)**
25/07/94	False alarm at 0748 hrs in Unit 30 or 31. MFB Report 2591 noted that steam from shower set off detector – Southwest 3 Circuit 40. **(Exhibit 57).**
00/08/94	KRS Fire Safety Upgrade Consultants Brief prepared. **(Exhibit 169 – Lai's file Page 105)**
02/08/94	Official fire drill practice held at Unit 31 at 9:51pm. The observations noted were *"No supervision of clients in yard, some difficulty in getting clients up for evacuation and stay together"*. **(Exhibit 294)**
05/08/94	SO George of the MFB attended Unit 4 to find a broken BGA. **(Exhibit 57 – 56315)**
14/08/94	SO Goddard of the MFB attended Unit 4 to find a broken BGA. **(Exhibit 57 – Report 56323)**
19/08/94	Jonkars attended Unit 25 to find a broken BGA. **(Exhibit 227 – Stewart's file – Service & Field Instruction 1210)**
24/08/94	ULA/SSL Report on Fire Safety Audit for Kew Training Centre released. The report contained trenchant criticism of the fire safety system and noted that untenable conditions could develop within a quick time before a full evacuation. The report recommended a smoke detection system to all Units and sprinklers as urgent. **(Exhibit 143)**

14/09/94	ULA registered their expression of interest for the Principal Engineering Consultant for the Fire Services Upgrade Project in a letter to John Taylor. **(Exhibit 169 – Lai's file Page 120-1)**
27/09/94	Paul Caras's General Service Plan for the following year was prepared by Lesley Vincent.. It recorded: *"Displays a range of challenging behaviours – Arson (if opportunity) – See attachment A."* The Attachment recorded: *"Arson – Will try to set alight and burn flammable items, if he can obtain matches or a lighter."* This was not followed up on his Individual Program Plan. **(Exhibit 131A)**
03/10/94	John Taylor wrote to ULA regarding their expression of interest for the Fire Services Upgrade and Ring Main Upgrade and invited them to forward a submission in anticipation of an interview on 20/10/94. **(Exhibit 169 – Lai's file Page 119)**
10/10/94	John Taylor sent ULA a copy of the consultancy brief in advance of the interview on 20/10/94. **(Exhibit 169 – Lai's file Page 113)**
29/10/94	False alarm at 1342 hrs in Unit 30 or 31. SO Condon noted on Report 2980 that: *"Staff having barbeque outside building left open door. Smoke set off detector in hall entrance."* **(Exhibit 57)**
00/11/94	ULA/Warrington Fire Services Fire Safety Audit for the Sandhurst Training Centre in Bendigo is released and includes among its recommendations, automatic door strikes. **(Exhibit 258.64 – White's statement PW9)**
00/11/94	Units 30 and 31 were amalgamated. John Eyre appointed as Unit Manager for the amalgamated Unit. In relation to the handover he gave evidence as follows: *"—There was a form of a handover, but it was inadequate and very brief. I was led to believe that the unit manager that I was taking over from, Ms Lesley Vincent, had been directed by her union, which she was at that stage an active member of, in this particular issue, that she – that that was not to occur, and I – from my memory I recall she was directed by the executive to do some form of handover, but the handover was – for a unit like that should take days to familiarise yourself with individual clients, the behaviour problems, et cetera, it was over about an hour or two.* *Did you ever know a handover like that before?—No.* *- – - or since?—No.* *It was totally unsatisfactory?—Yes.* *Under the circumstances of the climate at the time, that's exactly what happened?—That's what happened under the climate, yes."* *Eyre also gave evidence that he was not aware of the information on Caras' file re. fire lighting behaviour. He did not manage him as a fire risk during his period as the 30/31 Unit Manager although the Unit staff may have done so.* He gave evidence that the majority of staff voluntarily left the Unit during his time. **(Exhibit 258.11 Eyre's statement and Eyre's evidence on 17 April 1997 at Page 6812)**
01/11/94	False alarm at 1610 hrs in Unit 30 or 31. MFB Report 73 noted that: *"Workers having BBQ left door open, smoke entered building and set off alarm."* **(Exhibit 57).**
02/11/94	Jonkars (S Neicho) attended Unit 7-8 to find a broken BGA. *(Exhibit 227 – Stewart's file, Service & Field Instruction 2158)*
03/11/94	SO Kelly of the MFB attended the Perkins Centre to find a broken BGA. **(Exhibit 57 – Report 276)**
06/11/94	False alarm at 1122 hrs. MFB Report 625 noted that a smoke detector was activated in a bedroom *– "2nd bedroom on Left – Kenny England's room".* Patrick O'Hare gave evidence that England's room was in the area that became Flat E at door 2. Les Neicho who attended the call gave evidence that he could not recall in which room the detector operated but that it could have been the bedroom indicated by O'Hare, although in his statement he states that he attended in the area that became Flat B. He gave evidence that the detector could have been in Flat E. He gave evidence that: *"I remember that name"*, meaning Mr England's name. Neicho noted in Service & Field Instruction 1226 that he replaced a faulty smoke detector. **(Exhibit 57, O'Hare's evidence of 2 December 1996 at Page 2288, Exhibit 193 – Neicho's statement, LJN21 and Neicho's evidence of 3 March 1997 at Page 4457-9)**
06/11/94	False alarm at 1659 hrs. The MFB Report noted that *"same detector operating as before".* **(Exhibit 57)**
10/11/94	Jonkars (S Moore) attended an unidentified Unit to find a broken BGA. **(Exhibit 227 – Stewart's file – Service & Field Instruction 2161)**

16/11/94	The Minister for Finance Ian Smith released the "Guideline – Building Act 1993 – Standards for Publicly Owned Buildings". Guideline 1 required new and existing buildings to conform to standards that public building works were completed in accordance with certified plans and fit for occupation. In particular, works on existing buildings were to be subject to an indication from a surveyor that an occupancy permit would be issued on the completion of the work. **(Exhibit 276)**
30/11/94	Jonkars (S Moore) attended Unit 19 to find the emergency light hanging off the roof. Stephen Moore repaired it and noted it on Service & Field Instruction 2165. **(Exhibit 227 – Stewart's file)**
10/12/94	SO Swiney of the MFB attended the Pool/Physio complex to find a broken BGA. **(Exhibit 57 – Report 1515)**
22/12/94	John Taylor wrote to ULA advising them that they were appointed as the fire safety upgrade consultancy to oversee implementation of upgrade. The Contract provided a scope of works, largely as suggested in the ULA/SSL August report. ULA were not appointed as consultants for the ring main project. **(Exhibit 169 – Lai's file Page 91)**
30/12/94	SO Kelly of the MFB attended the pool/physio complex to find a broken BGA. **(Exhibit 57 – Report 4539)**
00/01/95	Dr John Patterson , the Secretary of the Department of Health & Community Services sent a memo to all staff regarding clients involved with fire risk behaviour and recommended that staff consider a referral to the MFB's Juvenile Fire Awareness & Intervention Program. **(Exhibit 258.64 – White's statement PW2)**
28/01/95	Jonkars attended Unit 4 to replace 2 smoke detector with 2 thermal detectors due to damage with dust and dirt during works. There is no evidence that the smoke detectors were reinstalled. **(Exhibit 227 – Stewart's file Service & Field Instruction 1243)**
31/01/95	2nd meeting of the Project Control Group. Minutes prepared 3/02/95. Dominic Lai tabled an indicative programme for the work to be completed. The Project Control Group decided that ULA's scope of work included work packages CWP1, CWP3 and CWP4 (ie. smoke detection ,residential sprinklers and light and power modifications). ULA then designed the fire detection and sprinkler systems. Following the meeting, it was decided that Bill Mitchell of the Department of Planning & Development was to be the Construction Manager on site. **(Exhibit 169 – Lai's file Page 82)**
00/02/95	Gary Radler became the Acting Manager of Kew Residential Services until August 1995. **(Exhibit 258.1 – Radler's statement)**
22/02/95	ULA wrote to Taylor and confirmed the tender estimate as lower than previously advised. **(Exhibit 169 – Lai's file Page 24)**
24/02/95	3rd Meeting of the Project Control Group. The minutes were prepared on 25/02/95. **(Exhibit 169 – Lai's file Page 79)**
26/02/95	False alarm at 0635 hrs in Unit 30 or 31. SO Kelly reported in Report 3272 that : ''Aerosol spray used near smoke detector''. **(Exhibit 57)**
02/03/95	State Coroner Johnstone in the Inquest into the death of Thi Huot Ly (a case concerning a fire lit by an autistic child aged 11 in locked premises) made a number of recommendations directed to Fire Authorities and the Department of Health & Community Services in relation to the management of fire lighting behaviour of persons having diminished responsibility. Thus: *"(Recommendation 4 – Where there is high risk of fire associated with repeated fire lighting behaviour, installation of residential fire sprinkler systems may be appropriate to reduce the risk to property and potential for injury etc....Recommendation 5 – Health & Community Services identify and alert all of the agencies who may potentially deal with individuals with fire lighting behaviour and inform them of the need to assess risk using professional risk management techniques and advise as to the level of assistance available through the Fire Authorities."* **(Inquest finding – Case number 3055/92)**
02/03/95	State Coroner Johnstone recommended in the Inquest into the death of Tran Moc Qui in the same terms as the Inquest into the death of Thai Hout Ly. **(Inquest finding – Case number 3134/92)**

02/03/95	Gary Radler sent a memo to John Taylor noting that the fire system in some Units was deactivated during works. He asked that this be communicated to staff, that signs be placed over BGA's and that any established policy on the deactivation of alarms be provided to him. **(Exhibit 258.1 Radler's statement Annexure M)**
10/03/95	Gary Radler sent a memo to Pat Kelly, the Sector Manager – 2, which included Unit 30/31, noting that some staff had not received fire training for 5 years. It recorded that Anne Fischer would follow this up. **(Exhibit 258.1 Radler's statement Annexure O)**
16/03/95	Radler sent a memo to the Sector Manager – 3 regarding 2 clients who were identified as having fire-lighting behaviour in monthly reports. He was later informed that there was a mistake in filling in the forms and they did not exhibit this behaviour. **(Exhibit 258.1 – Radler's statement and Annexure L)**
17/03/95	Jonkars attended Unit 19 to replace a smoke detector activated by toaster with a thermal detector. Stephen Moore noted the change in Service & Field Instruction 1283. **(Exhibit 227 – Stewart's file)**
20/03/95	Gary Radler sent a memo to John Taylor about fire safety in Kew Residential Services Houses. **(Exhibit 258.1 Radler's statement Annexure P)**
22/03/95	Project Control Group Meeting regarding the role of the Office of Building. **(Exhibit 169 – Lai's file Page 77)**
28/03/95	Gary Radler sent a memo to John Taylor asking him to follow up memo of 20/03/95. **(Exhibit 258.1 Radler's statement Annexure P)**
28/03/95	4th Project Control Group Meeting. It was noted that the project now behind schedule due to the pending water main decision. **(Exhibit 169 – Lai's file Page 74)**
00/04/95 to 00/04/96	Jonkars conducted monthly testing of the indicator lights on main alarm panel and sub-panels. **(Exhibit 193 – Neicho's statement LJN18)**
00/04/95	Document titled "Fire Drill Overviews for Sector 2" noted that in Unit 30/31 the only internal access was through the kitchen and that this should be discussed with Facilities. **(Exhibit 258.1 – Radler's statement Annexure N)**
05/04/95	Gary Radler sent a memo to Sector Managers regarding Internal Locked Doors and suggesting a review of all Units. **(Exhibit 258.1 – Radler's statement Annexure S)**
07/04/95	5th Project Control Group Meeting. ULA presented an overview of the fire alarm and residential sprinkler systems proposed. **(Exhibit 169 – Lai's file Page 72)**
19/04/95	ULA provided a copy of the fire safety audit and the proposed schedule of works to Inspector Shane Wright of Fire Safety of the MFB. **(Exhibit 169 – Lai's file Page 5)**
24/04/95	ULA wrote to Taylor advising him that they had received 14 registrations of interest for the fire alarm and sprinkler system and that 7 possible contractors had been selected. **(Exhibit 169 – Lai's file Page 25)**
25/04/95	ProARK Pty Ltd drew up plans for the renovations of Unit 31 involving the creation of Flats C, D and E. In Flat E, the renovations involved the creation of a kitchen/living area out of two bedrooms. **(Exhibit 265)**
00/05/95	Wormald received tender documents for the Kew Residential Services fire system upgrade. **(Exhibit 211 – Howie's statement KH1)**
03/05/95	At about this date, Srini Vasan engaged Vincent Paino to certify plans for renovations for Unit 30/31 and the O'Shea building. Paino was engaged for $100. Paino states that Vasan told him that the occupants were *"elderly related persons"* and that they did not require assistance to evacuate. Paino attended Kew Cottages for a meeting and was given plans dated 04/04/95 showing a small bathroom/kitchen renovation. Paino was of the belief that Unit 30/31 had less than 20 occupants, therefore smoke detectors were not required. Paino did not inspect the site nor was he familiar with Kew Cottages and did not know that it housed the intellectually disabled. He asked if Unit 31 extended to the east and was told by Vasan that it was of no consequence. He did not know that the renovation was part of a larger building and understood only that Unit 31 existed. **(Exhibit 258.63 – Paino's statement, Exhibit 297 and transcript of 18 and 28 April 1997, Pages 6969, 6973, 6920, 6988-9, 6914, 6918,6971, 6985-6, 6919, 6878-9 and 6920-2)**

03/05/95	Gary Radler met with Pat Kelly, Sector Manager 2 (whose responsibility included 30/31) and noted in relation to Fire Training that *"Gary is to contact B Gunning to see if STAD can co-ordinate fire-training. (AHCOT to maintain portfolio responsibility)"*. **(Exhibit 358.1 Radler's statement Annexure O)**
04/05/95	Jonkars attended the Avenue Hostel to replace a missing underfloor detector. Skye Neicho filled in Service & Field Instruction 1298. **(Exhibit 227 – Stewart's file)**
08/05/95	Paino sent a fax to Vasan requesting four copies of the amended plans as certain doors would require a fire rating. Vasan phoned Paino and told him that any alterations were to be handwritten on the existing plan. Vasan then visited Paino at home and took him copies of the plans showing the whole of Unit 30/31 but Paino still did not realise the size of the building. **(Exhibit 258.63 – Paino's statement and transcript of 18 April 1997 Page 6920-1)**
09/05/95	Gary Radler sent a memo to AHCOT Team Leader and Sector 1 & 2 Managers about the night-time meal breaks and asked how AHCOT will relieve and how this would affect AHCOT's emergency response capacity. **(Exhibit 258.1 Radler's statement Annexure Q)**
10/05/95	Paino certified that the ProARK drawings of 25/04/95 complied with the Building Regulations 1994 and the BCA. This followed his discussions with Vasan. Paino made a handwritten notation on the plans that *"doors and walls to bedroom to have one hour fire rating"*. **(Exhibit 264)**
12/05/95	Official Fire Drill Practice at Unit 30/31 at 11:05pm. The notes recorded *"non compliant clients, unclear who is in charge, staff returned though the kitchen where the fire was and left the door wide open – fire not contained, too many rooms, locked doors – access between groups."*. **(Exhibit 294)**
16/05/95	Kew Cottage/Parents Association Liaison Meeting. The minutes recorded that *"Current fire safety issues ...discussed by John Taylor. 6 units currently only get warning, others relayed by central switchboard. New system ($1.6m) will upgrade fire security based on consultants recommendations including...smoke detectors in every building, springlocks in bed rooms and new ring main. Expressions of interest will be sought in very near future. Completed by September.*" **(Exhibit 233)**
16/05/95	6th Project Control Group Meeting. John Bentivologio took over from Emanuel Savona. **(Exhibit 169 – Lai's file Page 49)**
19/05/95	Jonkars attended Unit 2 to find 2 under-eve detectors damaged . Stephen Moore replaced them and noted this in Service & Field Instruction 0861. **(Exhibit 227 – Stewart's file)**
22/05/95	ULA wrote to John Taylor with a revised estimate of the cost of the upgrade project. **(Exhibit 169 – Lai's file Page 24)**
23/05/95	The renovation of Unit 31 begun with the conversion of a bedroom in the area that became Flat E into a bathroom. The renovations continued in October 1995 with the conversion of two bedrooms into the kitchen/living area of what became Flat E. No major works were done in the area that became Flat B at this time, only minor maintenance jobs by local staff including a toilet partition door was strengthened for which a drill was used **(Transcript of 3 March 1997 Page 4418-9, Transcript of 3 April 1997 Page 5980, Transcript of 8 April 1997 Page 6116 and Exhibit 176 – Vasan's statement as amended and Transcript of 2 April 1997 Page 5824)**
24/05/95	Jonkars (S Neicho) replaced 2 smoke detectors (and one base) filled with dust in (Jonkars assert) Unit 30 with thermals (Service & Field Instruction 0865). These were in the corridor of what became Flat B at 39/35 and 39/39. Skye Neicho did not know that renovations were being carried out until he arrived at the units. He gave evidence that it is possible that the detectors were in Flat E given that there were no renovations carried out in Flat B at the time. He gave evidence that he recalled masonry drills were being used at the time to drill concrete that created the dust. At the time of the fire there was a thermal detector at 39/35 and a smoke detector at 39/39. **(Exhibit 193 – L Neicho's statement LJN21, Exhibit 181 – S Neicho's statement, Skye Neicho's evidence of 19 February 1997 at Page 3851-2 and Exhibit 186)**
25/05/95	After attending a PCG meeting, Radler sent a memo to the Manager, Disability Services to express his concern about the delay in the Fire Protection upgrade and the $300 000 in consultant's fees. **(Exhibit 258.1 Radler's statement Annexure R)**

25/05/95	Radler sent a memo to Sector Managers about Fire Evacuation Drills and requested that the Managers organise drills with the MFB. **(Exhibit 258.1 Radler's statement Annexure N)**
26/05/95	False alarm at 2145 hrs in Unit 30 or 31. Report 2518 noted that " Steam activated Smoke detectors". **(Exhibit 57)**
26/05/95	Jonkars attended Unit 2 to find 3 damaged detectors. Skye Neicho replaced the detectors and noted this on Service & Field Instruction 0866. **(Exhibit 227 – Stewart's file)**
29/05/95	Nabeel Kurban of the MFB wrote to ULA advising that *"Part sprinkler protection to these units may not provide the degree of life safety which is appropriate or desirable...The reduction of sprinkler coverage should not be an economic consideration, as life safety cannot be expected should fires occur in unsprinklered areas.."* **(Exhibit 169 – Lai's file Page 3)**
30/05/95	Official Fire Drill Practice at Unit 30/31 at 10:48pm. The notes recorded *"chairs on balconies were blocking the stairways, no on [sic] took control, buildings were not inspected for persons remaining, staff did not immediately evacuate, uncooperative clients".* **(Exhibit 294)**
01/06/95	Dr John Patterson of The Department of Health & Community Services authorised the Department of Planning & Development to be the principal for upgrade contract. William Mitchell is the Department of Planning & Development representative and tender administrator. **(Exhibit 258-20 Mitchell's statement)**
01/06/95	7th Project Control Group Meeting. A timetable for the tender process is discussed. **(Exhibit 169 – Lai's file Page 46)**
02/06/95	Three domestic smoke alarms were installed in Unit 30/31 by Kew Residential Services maintenance staff as directed by Gary Radler who had directed this because of the renovations in this Unit. **(Exhibit 176 – Vasan's statement)**
16/06/95	Jonkars attended Unit 7-8 to find a damaged detector. Stephen Moore replaced the detector and noted it on Service & Field Instruction 0803. **(Exhibit 227 – Stewart's file)**
23 – 24/06/95	Jonkars (Stephen Moore with Skye Neicho) replaced a smoke detector in the area that became Flat E with a thermal detector at 39/21. Service & Field Instructions 0891-2 refers to the works converting bedroom to bathroom resulting in concrete dust. Circuit 39 was isolated over the night of 23/06/95 because the concrete was wet and Stephen Moore couldn't get access until the next day. Unit 30/31 remained unprotected overnight. Les Neicho gave evidence that he disapproved of this and lectured his staff on this. He would have preferred that Moore cut the wires above the detector and rejoined them. Moore gave evidence that he definitely replaced the detector and didn't clean it as the Service & Field Instruction suggested, and made a mistake by not charging for the replacement. **(Exhibit 193 – LJN21, Exhibit 185 – Moore's statement, Moore's evidence of 21 February 1997 at Page 4047-8 and 24 February 1997 at Page 4091-2 and Evidence of Neicho on 3 March 1997 at Page 4445-6)**
26/06/95	False alarm at 1664 hrs. MFB Report No. 2700 noted that a Smoke/Thermal detector was operating in an unoccupied room in Unit 30/31 and that there was no reason for the alarm. **(Exhibit 57)**
26/06/95	False alarm at 1700 hrs. MFB Report 2704 noted that the same detector as the previous call had activated. **(Exhibit 57).**
26/06/95	Jonkars attended Unit 30/31 and found a smoke detector in Unit 30/31 filled with dust due to work. Skye Neicho replaced the detector with a thermal detector and noted it on Service & Field Instruction 0894. **(Exhibit 193 -LJN21 and Exhibit 181 – S Neicho's statement)**
28/06/95	Wormalds submitted their tender for the Fire Services Upgrade. **(Exhibit 211 – Howie's statement KH2)**
01/07 – 30/11/95	Jonkars (S Neicho) conducted the annual tests of all the detectors at Unit 30/31 and the monthly test of main panel and noted it on report 8432. This was not a detailed report and was one page only. This was the last annual test before the fire. Stephen Moore gave evidence that he accepted that a large number of detectors were non-complying but did nothing about it as Les Neicho had told him in 1993 that there was no money for repairs. **(Exhibit 181 – S Neicho's statement, Exhibit 193 – LJN16 and LJN18 and Evidence of Skye Neicho of 19 February 1997 at Page 3383, 3861, 3873 and evidence of Stephen Moore of 24 February 1997)**

04/07/95	Department of Health & Community Services Program Management Circular titled "Fire Risk Behaviour – Reasonable Decision Making" is distributed. **(Exhibit 258.64 – White's statement PW3)**
11/07/95	Gary Radler attended a Supervision Meeting with Pat Kelly (Sector 2 Manager whose responsibility included Unit 30/31) and noted that a door was being placed into 30/31 to allow access if there was a fire in the kitchen. **(Exhibit 258.1 Radler's statement Annexure P)**
12/07/95	ULA provided a report to the Department of Health & Community Services regarding the tenders for fire service upgrade and recommended the acceptance of Wormald's tender. **(Exhibit 169 – Lai's file Page 16)**
17/07/95	Ken Howie of Wormalds attended a post tender meeting with the Department of Planning & Development ,ULA and Kew Residential Services. They discussed the asbestos clause in the contract and cost savings. **(Exhibit 211 – Howie's statement)**
21/07/95	Wormalds provided a revised quotation. **(Exhibit 211 – Howie's statement KH6)**
24/07/95	Jonkars attended Unit 7-8 to find 1 detector damaged. The invoice noted that Service & Field Instruction 1769 recorded that the detector was replaced. **(Exhibit 27 – Stewart's file, Service & Field Instruction 1769 not included)**
25/07/95	8th Project Control Group Meeting. The meeting received a report from the Office of Building as to the status of the project . Revised quotations were required for the revised scope of the works. **(Exhibit 169 – Lai's file Page 38)**
31/07/95	Ken Howie from Wormald, Bill Mitchell from the Department of Planning & Development, David Ulhorn from ULA, Srini Vasan and representatives from Ellas Electricks and Kilpatricks carried out an asbestos inspection at Kew Residential Services. **(Exhibit 211 – Howie's statement)**
31/07/95	Jonkars attended circuit 23 to change 6 heat detectors. The invoice noted that Service & Field Instruction 0819 recorded this attendance. **(Exhibit 27 – Stewart's file, Service & Field Instruction 0819 not included)**
31/07/95	Jonkars attended an unspecified unit for an underfloor detector head that had been removed. The invoice noted that Service & Field Instruction 0820 recorded that the detector was replaced. **(Exhibit 27 – Stewart's file, Service & Field Instruction 0820 not included)**
00/08/95	Kilpatricks provided an Asbestos Investigation for selected ceiling spaces at Kew Residential Services . **(Exhibit 211 – Howie's statement KH7)**
00/08/95	John Eyre was suspended as the Unit manager of Unit 30/3. Virkumar Gungaphul, previously the Deputy Unit Manager of Flats C, D and E was appointed as Acting Unit Manager until November when he was replaced by Rod Carracher. Gungaphul states that he became Acting Unit Manger in July 1995. As to the handover to Gungaphul, Eyre gave evidence as follows: *"Was there a handover between you and Mr Gungaphul in August 1995?—No, I wasn't given an opportunity."***(Evidence of John Eyre 17 April 1997 Pages 6829 and 6833, Exhibit 258.12 – Gungaphul's statement)**
03/08/95	Radler circulated a Mental Health Services Program Management Circular on "Fire Risk Behaviour – Reasonable Decision Making" from Jennifer Williams, Director of Psychiatric Services to all Unit and Sector Managers with the notation "action as required". **(Exhibit 258.1 – Radler's statement Annexure J)**
07/08/95	The Department of Planning & Development provided Wormalds with revised documentation prepared by ULA. The letter noted that the Department of Health required all work to be completed within 25 weeks. **(Exhibit 211 – Howie's statement KH8)**
15/08/95	First Project Control Group Meeting for the Construction Phase. The minutes noted that a revised tender price was expected from Wormalds. The minutes noted that "all options are to be investigated to eliminate the need for access to asbestos contaminated ceilings. The following options were discussed ... Unit.31 – remove asbestos". **(Exhibit 170)**
16/08/95	Wormald provided a revised quotation to Bill Mitchell. **(Exhibit 211 – Howie's statement KH9)**

17/08/95	There was a further meeting regarding the asbestos issue. Bill Mitchell, David Ulhorn, Dominic Lai, Srini Vasan and John Taylor attended with Paul Griffith and Ken Howie from Wormald. Ken Howie made notes of the meeting. **(Exhibit 211 – Howie's statement KH10)**
17/08/95	Bill Mitchell of the Office of Building sought ULA's opinion on the Wormald's revised price for the revised scope of works. **(Exhibit 169 – Lai's file Page 15)**
28/08/95	Amcol provided an asbestos audit largely agreeing with Kilpatricks' audit. **(Exhibit 176 – Vasan's statement SV18)**
00/09/95	At about this time or before, Peter Johnson of SSL held discussions with David Ulhorn of ULA regarding the renovations of some units and the effect on the upgrade. He gave evidence as follows: *"Approximately when did you have those discussions?—I can't actually recall the exact time, but I would have thought some months prior to the October date. What was the substance of the discussions?—I advised him that we were, although the plans had already been done, and they had gone out to tender, that there were going to be some minor changes to Unit 31 and that 5 and 29 would need to be resigned when those plans were ready."* Dominic Lai states that he was unaware of the refurbishment works until 31 October 1995. **(Transcript of 9 April 1997, Page 6281-2, Exhibit 142 – Lai's supplementary statement)**
00/09/95	Francene McCartin was appointed the Manager of Kew Residential Services , replacing Gary Radler. **(Exhibit 58 – McCartin's statement)**
Early/09/95	Ampol engaged by Srini Vasan and the Project Control Group to remove minor asbestos from Units 30/31 as recommended by Kilpatricks. **(Exhibit 176 – Vasan's statement SV19)**
07/09/95	Kilpatricks advised Ampol that Unit 30/31 was asbestos free after Kilpatricks perform an inspection following Ampol's removal work. **(Exhibit 176 – Vasan's statement SV20)**
09/09/95	Radler sent a memo to the IDS BIST staff to inform them of Departmental Circular (distributed to Unit Managers on 03/08/95) and the MFB/CFA's Juvenile Fire Awareness and Intervention Program and asked them to inform all staff on their teams. **(Exhibit 258.1 Radler's statement Annexure K)**
13/09/95	2nd meeting of the Project Control Group – Construction Phase. The tenders were discussed and Wormalds was accepted. ULA were to provide revised drawings. **(Exhibit 170)**
22/09/95	Taylor invited Noel Arnold to provide a fee proposal for asbestos risk assessment at Kew Residential Services excluding roof spaces. **(Exhibit 258.61 – Bianchi's statement)**
23/09/95	Jonkars attended circuit 32 to find a detector damaged. The invoice noted that Service & Field Instruction 1788 recorded that it was replaced. **(Exhibit 227 – Stewart's file – Service & Field Instruction 1788 not included)**
27/09/95	The Department of Planning & Development advised Wormalds that their quote had been accepted. **(Exhibit 211 – Howie's statement KH11)**
00/10/95	There were further renovations to Unit 31 as part of the creation of Flat E. Two bedrooms in the Flat E area were converted to a living/kitchen area. **(Transcript of 3 April 1997 Page 4418-9, Transcript of 2 April 1997 Page 5978-9 and Transcript of 8 April 1997 Page 6116-7)**
04/10/95	Wormalds took possession of the site and commenced work. **(Exhibit 215 – Hoskin's statement)**
07/10/95	Jonkars attended the Avenue Hostel to find an underfloor detector damaged. Stephen Moore replaced it and noted it on Service & Field Instruction 0849. **(Exhibit 227 – Stewart's file)**
20/10/95	Deputy State Coroner West recommended in the Inquest into the deaths of five residents of Melton Court Hostel for the Aged that residential sprinkler systems be made mandatory in all supported residential services and that consideration be given to reviewing staff/client ratios for night management in such services. **(Inquest finding – Case number 864/94, 865/94, 930/94, 1002/94 and 1300/94)**
26/10/95	Jonkars attended the Avenue Hostel to find 2 damaged detectors. Stephen Moore replaced them and noted it on Service & Field Instruction 1796. **(Exhibit 227 – Stewart's file)**

27/10/95	Jonkars attended the chapel to find 4 visible detectors with damage and 1 hanging from its wiring in the roof space. Stephen Moore replaced them and noted this on Service & Field Instruction 1799. **(Exhibit 227)**
31/10/95	Dominic Lai learnt of the refurbishment works to Unit 31 on this date at a Project Control Meeting when a request was made for the completion of the redesign of the fire safety works to Unit 31. There are no minutes of a Project Control Meeting on this date. **(Exhibit 142 – Lai's supplementary statement)**
00/11/95	Vasan discontinued his involvement in the Project Control Group. He had expressed his dissatisfaction with the number of sprinkler heads (10) in Unit 15 which were less than indicated on the tender (34). He was told that the tender only indicated "design intent" and that the 10 sprinkler heads were superior. **(Exhibit 176 – Vasan's statement)**
00/11/95	Jonkars completed the monthly test on the main panel. Travis Cox noted that service books were required for the sub-panels on report 8457. **(Exhibit 193 – Neicho's statement LJN18)**
02/11/95	Srini Vasan instructed Jonkars to check that smoke detectors in the newly renovated Flat C conformed to AS1670 of 1995. Stephen Moore inspected the detectors and gave evidence that there were smokes in all the bedrooms (see positions 39/17, 39/22, 39/23 and 39/25 on the "January Plan"). He replaced two smoke detectors in the kitchen/living area (at 39/18 and 39/19) with thermal detectors. He used one of the smokes to replace a thermal at 39/4 in the Flat D area. Service & Field Instruction 0850 noted this attendance. Moore gave evidence that he kept no notes of his observations and that he cannot remember if there was a smoke detector located at the eastern end of the corridor (39/24). Moore could not explain why the smoke detectors failed at the time of the fire. He gave evidence that he could not recall going into each bedroom but that he did not need to go into the room to identify that there was a smoke detector in that room. **(Exhibit 193 – LJN21, Exhibit 176 – SV14, Exhibit 185 – Moore's statement and evidence of 21 February 1997 at Page 4057-9)**
05/11/95	Clients moved back into Unit 31 after renovations. **(McCartin's evidence – Transcript of 17 April 1997 Page 6857)**
08/11/95	3rd meeting of the Project Control Group – Construction Phase. The minutes recorded that *"all asbestos will be removed from ceiling spaces by 17 November 1995"*. **(Exhibit 170)**
08/11/95	Jonkars attended Avenue Hostel and found a damaged underfloor detector. L Neicho removed the detector and replaced it and noted it on Service & Field Instruction 0973. **(Exhibit 227 – Stewart's file)**
12/11/95	Rod Carracher was appointed as the acting Unit manager of Unit 30/31. He took over Virkumar Gungaphul who handed-over to him. Carracher gave evidence that he was not aware of any client with a fire lighting problem. He did not read the Caras profile and did not read all the files, as they were jumbled and needed work. When Carracher commenced, there were some 24 GSP's outstanding. Mr Carracher was not a substantive MRN3 so was not a candidate for the permanent position. **(Exhibit 129 – Carracher' statement and evidence of 12 December 1996 at Page 2716, 2791, 2718, 2721, 2728-9, 2738-9, 2764, 2740-1)**
13/11/95	Jonkars attended the Avenue Hostel and found an underfloor detector missing from its base. Skye Neicho replaced it and recorded this on Service & Field Instruction 0977. **(Exhibit 227 – Stewart's file)**
14/11/95	Jonkars attended Units 28-29 and found a damaged detector. Stephen Moore replaced it and noted it on Service & Field Instruction 0761. **(Exhibit 227 – Stewart's file)**
14/11/95	Minutes of Site Meeting record that *"WFS stated that they cannot guarantee the integrity of existing wiring or supply as wired drawings. They will test each existing circuit for alarm and fault condition prior to disconnection."* This statement was repeated in the Minutes for the next five site meetings until 30/01/96. **(Exhibit 282)**
25/11/95	Jonkars attended Unit 11 and found the circuit locked in alarm. The air conditioning unit in the ceiling had caught fire and had been fully extinguished. Stephen Moore noted this on Service & Field Instruction 0773. The MFB attended and this was noted on an Incident Report. Due to Industrial action, few details were recorded on the MFB Report. **(Exhibit 227 – Stewart's file and Exhibit 115 (2) – selected fire reports)**

28/11/95	Wormald sought approval from Bill Mitchell at the Office of Building to use electrical contractors, Ellas Electricks, for the upgrade. ULA notified Mitchell that it does not object. **(Exhibit 218)**
28/11/95	Jonkars attended the chapel to find a detector hanging from the new roof space, shorting and causing alarms. Stephen Moore reattached and noted this on Service & Field Instruction 0778. **(Exhibit 227 – Stewart's file)**
29/11/95	The Office of Building wrote to Wormalds approving the use of Ellas Electricks. **(Exhibit 218)**
00/12/95	ULA prepared plans of units for carrying out the upgrade. A plan of Unit 30/31 was drawn up showing the proposed changes. **(Exhibit 158)**
01/12/95	ULA advised Wormalds that Units 5, 29 and 31 would need to be re-documented due to changes in internal fit-out after the tender. **(Exhibit 169 – Lai's file Page 63)**
04/12/95	Wormald wrote to Bill Mitchell regarding various issues of access which were effecting productivity and time frames. **(Exhibit 215 – Hoskin's statement BH2)**
11/12/95	Site Meeting 3. **(Transcript of 3 March 1997 Page 4471)**
13/12/95	Bill Mitchell wrote a reply to Wormald following their meeting over access times, resolving various issues. **(Exhibit 215 – Hoskin's statement BH3)**
14/12/95	Jonkars attended Unit 7-8 and found a broken BGA. It is recorded on the Invoice that Service & Field Instruction 0797 recorded that it was replaced. **(Exhibit 227 – Stewart's file – Service & Field Instruction 0797 not included)**
16/12/95	False alarm at 1226 hrs on circuit 39 in Unit 30 or 31. The MFB report recorded *"There is a BBQ outside Unit 30 or 31."* The report was not completed due to industrial action. **(Exhibit 57)**
16/12/95	Second false alarm at 1333 hrs. The MFB report recorded *"Alarm has been set off by BBQ".* The report was not completed due to industrial action. **(Exhibit 57)**
18/12/95	Ennio Bianchi of Noel Arnold attended a meeting with John Taylor and Srini Vasan at Kew Residential Services and discussed a revised scope of works. Unit 30/31 was not to be included in the revised works. The work was to be a visual inspection only. **(Exhibit 258.61 – Bianchi's statement)**
19/12/95	Site Meeting 4. David Ulhorn of ULA recorded note *"Unit 31 amended drawing tabled....raised for repricing".* **(Exhibit 169 – Lai's file Page 62)**
20/12/95	4th Project Control Group Meeting – Construction Phase. The minutes recorded that *"All asbestos has been removed from ceiling spaces."* **(Exhibit 170).**
30/12/95	Jonkars attended the hospital and found a broken BGA and 1 detector head missing. Stephen Moore replaced the detector and glass and noted it on Service & Field Instruction 0796. **(Exhibit 227 – Stewart's file)**
00/01/96	Leslie Neicho gave evidence that in January he prepared a second plan on a transparency of the detectors in Unit 30/31 based on Stephen Moore's handwritten plans of December 1993 and details of works performed in Unit 30/31 since December 1993. He had prepared a plan of Unit 30/31 in 1991. **(Exhibit 193 – Neicho's statement LJN10 – January plan and LJN8 – Moore's plan)**
00/00/96	Jonkars performed the monthly test of the fire protection system and recorded this on report 8462. **(Exhibit 193 – Neicho's statement LJN18)**
03/01/96	Jonkars (Skye Neicho) attended Unit 30/31 to replace a smoke detector on circuit 39 which had been activated by steam from a shower in an adjacent room. Stephen Moore gave evidence that the detector was in the corridor of Flat E (39-20) and was replaced by a thermal detector. Service & Field Instruction 0988 referred to this attendance. There are no MFB records of a false alarm on circuit 39 that day. **(Exhibit 193 – LJN21, Exhibit 181 – Skye Neicho's statement, Evidence of Stephen Moore of 13 February 1997 Page 3649-50 and Exhibit 57 – MFB False Alarm reports)**

15/01/96	Wormald started work in Unit 30/31. There were no as-installed wiring diagrams available as to the existing wiring and Wormalds did not prepare any. Rob Tregonning gave instructions on site as to the position of the wiring as it was visually rather than physically traced. **(Exhibit 215 – Hoskin's statement as amended and evidence of Hoskin on 12 March 1997 Page 4977-4986)**
16/01/96	Wormald's second day of work on Units 30/31.
16/01/96	Site Meeting 5. The minutes recorded that *"Unit 30/31 30% complete" – "ULA to advise if : door strikes are to be reinstated (U13/14, U17/18, U19/20)"* . **(Exhibit 175)**
17/01/96	Wormald's third day of work on Unit 30/31. The work ceased due to the discovery of asbestos in the ceiling space by plumbers. Work did not recommence prior to the fire. Wormald's faxed Bill Mitchell about this. As a result of the discovery of asbestos, Srini Vasan contacted ?Kilpatrick and Ampol. Kilpatricks inspected the roof space and found no risk of exposure to asbestos but the presence of synthetic mineral fibre and so recommended that future work be in protective clothing. **(Exhibit 176 – Vasan's statement and Exhibit 215 – Hoskin's statement BH4)**
18/01/96	Wormald wrote to Bill Mitchell and advised that their staff would not re-enter the Unit 30/31 roof space until all ceiling insulation removed or ventilation installed so that workers could wear protective clothing in middle of summer. **(Exhibit 215 – Hoskin's statement BH5)**
18/01/96	Wormald wrote to Bill Mitchell noting Wormald's employee's serious misgivings about the clearance certificates of Kilpatrick and Azcor. **(Exhibit 215 – Hoskin's statement BH7)**
19/01/96	Mitchell wrote to Wormald advising that Kew Residential Services had undertaken to remove all ceiling insulation from Units 30/31 and requesting that work in that unit stop until the insulation had been removed. and the roof certified as safe. **(Exhibit 215 – Hoskin's statement BH8)**
19/01 – 22/01/96	Wormald continued working in other Units. **(Exhibit 215 – Hoskin's statement)**
22/01/96	Wormald held a meeting of employees and sub-contractors and the Wormald Occupational Health & Safety Manager at Kew Residential Services. The manager and staff decided that there would be no further work on any roof space unless certain safe guards were met. These were:*".Appropriate respirators must be worn in roof spaces;* *1.Disposable coverables and gloves etc. to be worn in roof spaces;* *2.Showering/cleaning of all personnel before meals and end of work by means of portable/staff shower, decontamination unit."* Items 1 and 2 had been implemented and Wormald wrote to Bill Mitchell on 23/02/96 asking for a variation on the contract to account for the costs. **(Exhibit 215 – Hoskin's statement BH9)**
22/01/96	Azcor found asbestos in Unit 13/14 which had already been worked on by Wormald. Azcor removed the asbestos and issued a clearance the next day. **(Exhibit 234 – Taylor's statement)**
22/01/96	Jonkars attended Unit 28/29 and found 2 damaged detectors due to renovations. Stephen Moore replaced the detectors and noted it on Service & Field Instruction 1316 and 1317. **(Exhibit 227 – Stewart's file)**
24/01/96	False alarm at 1055 hrs on circuit 39 in Unit 30 or 31. MFB Report not completed due to industrial action. The AHCOT Book recorded for 24/02/96: *"Fire Alarm U/30/31 6-35AM Faulty Heat Detector MFB x 3 Evacuation".* Further information was sought from the Department of Human Services regarding this alarm – see the comments of Dr Neal and Mr Olle of 16 April 1997 at Page 6722-23. **(Exhibit 57, 119)**
25/01/96	Wormald discovered asbestos in Unit 26/27. **(Exhibit 215 – Hoskin's Statement)**
25/02/96	Wormald faxed Mitchell that *" Currently all existing fire alarms in Unit 331/31 are still operational and have not altered in any form. All new equipment is inactive."* **(Exhibit 176 – Vasan's statement and SV27)**
29/01/96	5th Meeting of the Project Control Group – Construction Phase. The minutes recorded that asbestos was found in roof spaces, including Unit 30/31 and that it was to be removed. **(Exhibit 170)**
29/01/96	Bruce Hoskin from Wormald met with Bill Mitchell and John Taylor and confirmed that no further work was to be done in the ceiling space of Unit 30/31 until the insulation was removed as asbestos may have contaminated the insulation when the asbestos shaving was cut during the installation of skylights. **(Exhibit 215 – Hoskin's statement)**

29/01/96	Noel Arnold commenced their survey. Hall was told that the Unit 30/31 roof space had already been inspected. **(Exhibit 258.60 – Hall's statement)**
29/01/96	Jonkars changed all the smoke detectors in Unit 28-29 to thermal detectors due to the renovations. Skye Neicho recorded this in Service & Field Instruction 1388. **(Exhibit 227 – Stewart's file)**
30/01/96	6th Site Meeting. The minutes record that Wormald advised that *"Unit 30/31 installation 70% complete. On hold until asbestos removed."* The contract completion date was noted as 17/04/96. **(Exhibit 215 – Hoskin's statement BH12)**
00/02/96	Jonkars performed the monthly test report on the main panel. Skye Neicho recorded it on report 8463. **(Exhibit 193 – Neicho's statement LJN18)**
01/02/96	Metro Asbestos Removalists quoted for the removal of all roof wool installation in roof of Units 30/31 for $7,000. Kew Residential Services engaged Metro to perform this task. (Exhibit 176 – Vasan's statement SV24)
02/02/96	Jonkars attended circuit 41 to find 4 damaged detectors, 1 BGA and 1 detector missing. Travis Cox noted on Service & Field Instruction 1394 that this was due to works. **(Exhibit 227 – Stewart's file)**
13/02/96	Wormald found asbestos in ceiling space of Unit 7/8 and Noel Arnold found asbestos in ceiling space of Unit 13/14. **(Exhibit 234 – Taylor's statement)**
14/02/96	Azcor gave a clearance for Unit 30/31 after the removal of synthetic mineral fibre by Metro Asbestos. Vasan forwarded the clearance certificate to Bill Mitchell to forward to Wormald and expected that Wormald would return to work on Unit 30/31. Wormald did not recommence work in Unit 30/31. **(Exhibit 176 – Vasan's statement and Exhibit 258.29 – Gough's statement)**
21/02/96	Mitchell instructed Wormald to cease working on any Kew Residential Services ceiling space until the completion of an inspection by an appropriate consultant as witnessed by Wormald. **(Exhibit 215 – Hoskin's Statement BH13)**
21/02/96	Mitchell engaged Noel Arnold to conduct inspections of ceiling space and inspections of certain Units but not Unit 30/31. **(Exhibit 258.60 – Hall's statement)**
23/02/96	Noel Arnold provided a written report regarding asbestos in Unit 25 and the Geiger building to Bill Mitchell. **(Exhibit 258.60 – Bianchi's statement)**
24/02/96	Jonkars attended the Pharmacy building to find a smashed detector. Skye Neicho replaced the detector and noted it no Service & Field Instruction 1004. (Exhibit 227 – Stewart's file)
25/02/96	False alarm at 630 hrs on circuit 39 in Unit 30 or 31. The MFB report does not contain any further details due to industrial action. The AHCOT book recorded "*Fire Alarm U/30/31 6-35AM Faulty Heat Detector MFB x 3 Evacuation*". Further information was sought from the Department of Human Services regarding this alarm – see the comments of Dr Neal and Mr Olle o f16 April 1997 at Page 6722-23. **(Exhibit 57, 119)**
26/02/96	Jonkars attended Unit 9 and found a detector head damaged. Stephen Moore replaced it and noted it on Service & Field Instruction 1332. **(Exhibit 227 – Stewart's file).**
26/02/96	Jonkars attended the Avenue Hostel and found 2 damaged detectors. Stephen Moore replaced them and noted it on Service & Field Instruction 1333. **(Exhibit 227 – Stewart's file)**
26/02/96	Jonkars attended the Avenue Hostel to find an underfloor detector head missing . Stephen Moore replaced it and noted it on Service & Field Instruction 1334. **(Exhibit 227 – Stewart's file)**
29/02/96	Noel Arnold provided the ceiling space inspection reports re. Units 9, 11, 3 and 4 to Mitchell. **(Exhibit 258.60 – Bianchi's statement)**
03/03/96	Asbestos found in the ceiling space of Unit 9. **(Exhibit 234 – Taylor's statement)**
05/03/96	Kevin Hall of Noel Arnold discovered asbestos in ceiling space of Unit 13/14 and 15/16. **(Exhibit 258.60 – Bianchi's statement)**

12/03/96	Jonkars performed the monthly test of the main panel. Skye Neicho noted this on report no 8464. **(Exhibit 193 – Neicho's statement LJN18)**
12/03/96	Jonkars attended circuit 41 (Units 7/8) and found a damaged detector. Stephen Moore replaced it and noted it on Service & Field Instruction 1346. **(Exhibit 227 – Stewart's file)**
14/03/96	Site Meeting No 9. The minutes recorded that "Unit 30/31 70% complete". **(Exhibit 215 – Hoskin's statement)**
14/03/96	The Constructions Electrical Plumbing Union imposed a work ban on Wormald personnel and sub-contractors working in ceiling spaces due to the discovery of asbestos. **(Exhibit 215 – Hoskin's statement BH5)**
18/03/96	Jonkars attended Unit 7/8 and found two detectors damaged by feral animal damage. Stephen Moore replaced them and noted this on Service & Field Instruction 1017. **(Exhibit 227 – Stewart's file)**
19/03/96	Bruce Howie of Wormald wrote to Bill Mitchell to inform him of the work ban. **(Exhibit 215 – Hoskin's statement BH5)**
19/03/96	Wormald asked Noel Arnold to provide a quote for a safe work practice for Wormald's staff in the roof space. **(Exhibit 258.60 – Hall's statement)**
20/03/96	Bill Mitchell asked Noel Arnold to provide an unconditional asbestos clearance for a number of ceiling spaces. Kevin Hall of Noel Arnold told Mitchell that this was impossible because asbestos could be in the insulation. **(Exhibit 258.60 – Hall's statement)**
21/03/96	Kew Cottages/Parents Association Liaison Meeting. The minutes record that *"John Taylor reported that the Fire Upgrade was approximately 85% completed and should be completed by June 1996. The contractors have raised concern about asbestos in the ceiling space. The asbestos will be removed and a follow up audit completed."* He described the features of the new system.. **(Exhibit 233)**
27/03/96	6th Project Control Group – Construction Phase Meeting. The minutes record that the meeting discussed strategies for the removal of asbestos and that a revised scope of works for Units including Unit 31 was prepared by ULA and agreed upon by ULA, Wormalds and the Office of Building. The next meeting was to be 29/05/96. **(Exhibit 170)**
29/03/96	Bill Mitchell met with Noel Arnolds to discuss the costs of removal of loose insulation from ceiling space. **(Exhibit 258.60 – Bianchi's statement)**
End/03/96	Wormald had not received a clearance to work on Unit 30/31. Mitchell's instructions from 19/01/96, 30/01/96 and 21/02/96 not to work still applied and were complied with. **(Exhibit 215 – Hoskin's statement)**
End/03/96	Rod Carracher finished as the acting Unit manager of Unit 30/31. He was replaced by Sen Rengasammy. Carracher did not bring any issues regarding Caras to Rengasammy's attention: his evidence was: *When you handed over to Mr – - -?—Rengasammy? Rengasammy, thank you – I take it that you didn't bring anything to his attention in regard to Mr Caras?—No."* *McCartin gave evidence of Rengasammy's appointment as follows: "So those matters also must have rung some bells with management about perhaps the problems of a break of continuity and the difficulties faced by the staff trying to manage Unit 30/31?—Yes, they did, and it was the – for that exact reason that Sen Rengassamy who was one of the more senior substantive and highly regarded unit managers, was moved from his unit to Unit 30/31.* *He was moved there a week before the fire; is that right?—Yes, after Rod Carracher had obtained another position.* *Was it understood then just before the fire, that really things were getting to an unsatisfactory state in terms of managing client files and managing clients at Unit 30/31? —No, it was understood that there'd been a significant change of leadership of the unit manager in that we needed a substantive unit manager to go in and give the unit a longer period, a more settled period of time. I don't think that there was a perception that the clients weren't being cared for well, that there were issues – client care issues, but that it had been a higher turnover than we would – than is normal for that unit."* **(Exhibit 129 – Carracher's statement, Transcript of 12 December 1996 Page 2795 and Transcript of 17 April 1997 Page 6860-1)**

01/04/96	Mitchell provided a new work schedule to Wormald stating that Noel Arnold would guarantee that there was no asbestos in the ceiling space and that Noel Arnold had not yet provided a certificate. **(Exhibit 215 – Howie's statement BH15)**
02/04/96	Jonkars performed the monthly test of the admin panel. Travis Cox recorded it in report 8465. **(Exhibit 193 – Neicho's statement LJN18)**
02/04/96	Noel Arnold prepared the work schedule for the abatement of asbestos roof coping at Units 13/14 and 15/16. They had been asked by Bill Mitchell to urgently inspect non-residential buildings and did so on the following two days. **(Exhibit 258.60 – Hall's statement)**
08/04/96	Fire in Flat E of Unit 31. MFB received alarm at 22:56:12 hours from a detector on Circuit 39. Nine died in the fire. Vasan believed that Unit 30/31 was protected by the old fire system and that all bedrooms in Flat E were protected by hard wired smoke detectors. Wormalds had not received a clearance certificate regarding asbestos. **(Exhibit 3 – MFB Fire Investigation Report, Exhibit 176 – Vasan's statement and Exhibit 215 – Hoskin's statement)**
10/04/96	Meeting at Kew Residential Services attended by Wormald, Bill Mitchell, ULA and Manny Savona regarding the fire safety at Kew Residential Services. Savona asked ULA to provide a report as to the existing electronic door locks. **(Exhibit 175)**
11/04/96	Jonkars wrote to Robert Stewart noting that they had made a mistake in their tender and due to the reduced amount of work they would be performing, the tender sum should be $1787 rather than $3250. **(Exhibit 227 – Stewart's file)**
18/04/96	Jonkars engaged to maintain the fire protection system at Kew Residential Services from 01/04/96 to 30/03/97 for $3250. **(Exhibit 227 – Stewart's file)**
23/04/96	Robert Stewart noted the revised price for the Jonkars contract. **(Exhibit 227 – Stewart's file)**
23/04/96	Inspector Martin of the Metropolitan Fire Brigade Fire Investigation & Analysis Unit asked QFF Petersen and LFF Pillinger to contact Jonkars and obtain any plans of fire safety system in Unit 30/31. Pillinger rang Les Neicho and recorded the conversation in a diary note. Pillinger also sent a fax to Neicho which asked "Les, could you please indicate those fittings that were installed, what they were and any proposed fittings". Petersen also rang Neicho who arranged to attend the MFB next day. (Exhibit 244 – Pillinger's statement, Exhibit 246 – Petersen's statement and Exhibit 245 – Martin's statement)
24/04/96	Les Neicho attended the MFB and met Petersen. He gave Petersen a bundle of plans of units at Kew Residential Services including drawing S12716 which shows Unit 30/31 before Flat E is completed. According to Petersen, Neicho told Petersen that this drawing was the only plan of Unit 30/31 that he had. Neicho also told Petersen some details about changes to detectors in Flat E of Unit 31. Petersen states that the plan known as the "January Plan" (Exhibit 193 – Neicho's statement LJN10) was not produced to him. Later that day, Martin, Pillinger and SO James attended Kew Residential Services to discuss the issue of plans with Srini Vasan. Martin and Pillinger deny seeing the January plan until December 1996 when it was provided with Les Neicho's statement. **(Exhibit 244 – Pillinger's statement, Exhibit 246 – Petersen's statement and Exhibit 245 – Martin's statement)**

APPENDIX 2.6

THE MFB CHRONOLOGY OF KNOWN DETECTOR DAMAGE

14/11/91	Jonkars (Talbot) repaired a BGA and replaced three defective heat detectors in Unit 30/31 and noted this in Service & Field Instruction 0274. **(Exhibit 193 – L Neicho's statement and LJN21)**
11/12/91	Jonkars (Talbot) replaced a faulty BGA in Unit 30/31 and noted this in Service and Field Instruction 0297. **(Exhibit 193 – L Neicho's statement and LJN21)**
19/11/92	Jonkars attended at Unit 12 to find 2 damaged detectors, replaced them and noted this in Service and Field Instruction 2705. **(Exhibit 227 – Stewart's file)**
09/12/92	Jonkars (S Moore) attended circuit 51 to find 2 broken BGA glasses, replaced them and noted this in Service and Field Instruction 0321. **(Exhibit 227 – Stewart's file)**
Early/93	Jonkars attended the Avenue Hostel to find a damaged underfloor detector . They replaced the detector and noted it in Service & Field Instruction 0558. **(Exhibit 227 – Stewart's file)**
Early/93	Jonkars attended the pharmacy to remove a BGA that was activating due to continual breaking by person unknown. They noted this in Service & Field Instruction 0395. **(Exhibit 227 – Stewart's file)**
22/04/93	Jonkars (K Talbot) attended the Hamer Centre to find a broken thermal base. They replaced it and noted it in Service & Field Instruction 0652. **(Exhibit 227 – Stewart's file)**
29/05/93	SO Mackwell of the MFB attended the Hamer Wing to find a broken BGA. **(Exhibit 57 – Report 69904)**
04/07/93	SO Kelly of the MFB attended the Hamer Wing to find a broken BGA. **Exhibit 57 – Report 69936)**
15/07/93	Jonkars attended Unit 30 and Stephen Moore replaced a missing smoke detector head over a bed. He cannot remember the room. **(Exhibit 185 – Moore's statement and Service & Field Instruction 0703)**
25/07/93	Station Officer Stewart of the MFB attended to find a broken BGA in an unspecified Unit. **(Exhibit 57 – Report 5307)**
08/10/93	Jonkars (S Neicho) attended Unit 7-8 and found 2 damaged bar detectors. These were replaced and noted in Service & Field Instruction 0753. **(Exhibit 227 – Stewart's file)**
08/11/93	Station Officer Moore of the MFB attended the pool/physio and found a broken BGA. **(Exhibit 57)**
14/11/93	Station Officer Kelly of the MFB attended the pool/physio and found a broken BGA. **(Exhibit 57 – Report 73457)**
14/11/93	Station Officer Barnes of the MFB attended the pool/physio to find a broken BGA. **(Exhibit 57 – Report 73458)**
28/11/93	SO Cass of the MFB attended the pool/physio to find a broken BGA **(Exhibit 57 – Report 73464)**
16/04/94	SO Brown of the MFB attended Kew to find a broken BGA at an unspecified Unit. **(Exhibit 57 – Report 78608)**
26/04/94	SO Kelly of the MFB attended Unit 10 to find a broken BGA. **(Exhibit 57 – Report 78617)**
05/05/94	SO Goddard of MFB attended Unit 10 to find broken BGA. **(Exhibit 57 – Report 78623)**
07/05/94	SO Sweeney of MFB attended Unit 10 to find broken BGA. **(Exhibit 57 – Report 78623) .**
16/05/94	SO Goddard of the MFB attended the pool/physio complex to find a broken BGA. **(Exhibit 57 – Report 78631)**
21/05/94	SO Goddard of the MFB attended Unit 10 to find a broken BGA. **(Exhibit 57 – Report 78636)**

05/08/94	SO George of the MFB attended Unit 4 to find a broken BGA. **(Exhibit 57 – 56315)**
14/08/94	SO Goddard of the MFB attended Unit 4 to find a broken BGA. **(Exhibit 57 – Report 56323)**
19/08/94	Jonkars attended Unit 25 to find a broken BGA. **(Exhibit 227 – Stewart's file – Service & Field Instruction 1210)**
02/11/94	Jonkars (S Neicho) attended Unit 7-8 to find a broken BGA. **(Exhibit 227 – Stewarts file, Service & Field Instruction 2158)**
03/11/94	SO Kelly of the MFB attended the Perkins Centre to find a broken BGA. **(Exhibit 57 – Report 276)**
10/11/94	Jonkars (S Moore) attended an unidentified Unit to find a broken BGA. **(Exhibit 227 – Stewart's file – Service & Field Instruction 2161)**
30/11/94	Jonkars (S Moore) attended Unit 19 to find the emergency light hanging off the roof. Stephen Moore repaired it and noted it on Service & Field Instruction 2165. **(Exhibit 227 – Stewart's file)**
10/12/94	SO Swiney of the MFB attended the pool/physio complex to find a broken BGA. **(Exhibit 57 – Report 1515)**
30/12/94	SO Kelly of the MFB attended the pool/physio complex to find a broken BGA. **(Exhibit 57 – Report 4539)**
04/05/95	Jonkars attended the Avenue Hostel to replace a missing underfloor detector. Skye Neicho filled in Service & Field Instruction 1298. **(Exhibit 227 – Stewart's file)**
16/06/95	Jonkars attended Unit 7-8 to find a damaged detector. Stephen Moore replaced the detector and noted it on Service & Field Instruction 0803. **(Exhibit 227 – Stewart's file)**
24/07/95	Jonkars attended Unit 7-8 to find 1 detector damaged. The invoice noted that Service & Field Instruction 1769 recorded that the detector was replaced. **(Exhibit 27 – Stewart's file, Service & Field Instruction 1769 not included)**
31/07/95	Jonkars attended an unspecified unit for an underfloor detector head that had been removed. The invoice noted that Service & Field Instruction 0820 recorded that the detector was replaced. **(Exhibit 27 – Stewart's file, Service & Field Instruction 0820 not included)**
23/09/95	Jonkars attended circuit 32 to find a detector damaged. The invoice noted that Service & Field Instruction 1788 recorded that it was replaced. **(Exhibit 227 – Stewart's file – Service & Field Instruction 1788 not included)**
07/10/95	Jonkars attended the Avenue Hostel to find an underfloor detector damaged. Stephen Moore replaced it and noted it on Service & Field Instruction 0849. **(Exhibit 227 – Stewart's file)**
26/10/95	Jonkars attended the Avenue Hostel to find 2 damaged detectors. Stephen Moore replaced them and noted it on Service & Field Instruction 1796. **(Exhibit 227 – Stewart's file)**
27/10/95	Jonkars attended the chapel to find 4 visible detectors with damage and 1 hanging from its wiring in the roof space. Stephen Moore replaced them and noted this on Service & Field Instruction 1799. **(Exhibit 227)**
08/11/95	Jonkars attended Avenue Hostel and found a damaged underfloor detector. L Neicho removed the detector and replaced it and noted it on Service & Field Instruction 0973. **(Exhibit 227 – Stewart's file)**
14/11/95	Jonkars attended Units 28-29 and found a damaged detector. Stephen Moore replaced it and noted it on Service & Field Instruction 0761. **(Exhibit 227 – Stewart's file)**
28/11/95	Jonkars attended the chapel to find a detector hanging from the new roof space, shorting and causing alarms. Stephen Moore reattached and noted this on Service & Field Instruction 0778. **(Exhibit 227 – Stewart's file)**
14/12/95	Jonkars attended Unit 7-8 and found a broken BGA. It is recorded on the Invoice that Service & Field Instruction 0797 recorded that it was replaced. **(Exhibit 227 – Stewart's file – Service & Field Instruction 0797 not included)**

30/12/95	Jonkars attended the hospital and found a broken BGA and 1 detector head missing. Stephen Moore replaced the detector and glass and noted it on Service & Field Instruction 0796. **(Exhibit 227 – Stewart's file)**
22/01/96	Jonkars attended Unit 28/29 and found 2 damaged detectors due to renovations. Stephen Moore replaced the detectors and noted it on Service & Field Instruction 1316 and 1317. **(Exhibit 227 – Stewart's file)**
02/02/96	Jonkars attended circuit 41 to find 4 damaged detectors, 1 BGA and 1 detector missing. Travis Cox noted on Service & Field Instruction 1394 that this was due to works. **(Exhibit 227 – Stewart's file)**
24/02/96	Jonkars attended the Pharmacy building to find a smashed detector. Skye Neicho replaced the detector and noted it no Service & Field Instruction 1004. **(Exhibit 227 – Stewart's file)**
26/02/96	Jonkars attended Unit 9 and found a detector head damaged. Stephen Moore replaced it and noted it on Service & Field Instruction 1332. **(Exhibit 227 – Stewart's file).**
26/02/96	Jonkars attended the Avenue Hostel and found 2 damaged detectors. Stephen Moore replaced them and noted it on Service & Field Instruction 1333. **(Exhibit 227 – Stewart's file)**
26/02/96	Jonkars attended the Avenue Hostel to find an underfloor detector head missing . Stephen Moore replaced it and noted it on Service & Field Instruction 1334. **(Exhibit 227 – Stewart's file)**
12/03/96	Jonkars attended circuit 41 (Units 7/8) and found a damaged detector. Stephen Moore replaced it and noted it on Service & Field Instruction 1346. **(Exhibit 227 – Stewart's file)**
Unknown	Les Neicho observed a burn mark on a detector in the Aveneue Hostel. **(Transcript of 4 March 1997 Page 4305)**

APPENDIX 2.7

VILLAMANTA LEGAL SERVICE – SUMMARY OF RECENT FIRES AT KRS

MFB FIRE REPORTS 1985 – APRIL 1996

Date	Day of the week	Time	Location of fire	Supposed cause of fire
11/2/85	M	1601	IB	UH
31/3/85	Su	1129	O	UH, C
23/4/85	Tu	1230	ID	R
17/5/85	F	1026	IN	E
14/6/85	F	0522	IN	UH, C
13/09/85	F	1610	IN	UH (S)
Illegible record			IB	
20/11/85	W	1430	IB	R, C
25/3/86	M	1702	O	S
31/3/86	M	1421	O	S
25/4/86	F	1519	ID	R, C
30/5/86	F	1202	ID	R
13/2/87	F	1951	O	O
21/2/87	Sa	1809	O	UH, C
3/6/87	W	2043	O	R, C
8/12/87	Tu	0837	K	F
21/1/88	Th	1248	O	UH, C }
21/1/88	Th	2259	O	UH, C }
22/1/88	F	1305	O	UH, C }
2/2/88	Tu	1459	O	UH, C
15/3/88	Tu	1549	O	R, C
29/6/88	W	0225	ID	R, C
2/12/88	F	2347	O	O
18/1/89	W	1937	I	U
19/6/89	M	0732	ID	E
15/5/90	Tu	1706	IK	E
27/7/90	F	0936	I	E
28/3/91	Th	0958	IK	E
16/1/93	Sa	0352	1L	E
2/6/93	W	0749	IK	F

25/6/93	F	1727	IK	F
3/7/93	Sa	1709	IK	F
6/7/93	Tu	0801	IK	F
13/7/93	Tu	1356	ID	R, E
10/8/93	Tu	0818	IK	F
16/8/93	M	0715	IK	F
4/11/93	Th	0803	IK	F
9/11/93	Tu	0104	IL	E
17/11/93	W	0755	IK	F
3/12/93	F	0806	IK	F
7/12/93	Tu	0713	IK	F
8/12/93	W	0640	IK	F
9/1/94	Su	0823	IK	F
10/1/94	M	0828	IK	F
24/1/94	M	0635	IK	F
31/1/94	M	0718	IK	F
17/2/94	Th	0725	IK	F
13/3/94	Th	0712	IK	F
7/3/94	M	1858	ID	R, C
24/6/94	F	0715	IK	F
20/7/94	W	0929	IK	F
1/8/94	M	0319	I	UH, E
9/8/94	Tu	1953	IL	E
21/8/94	Su	1217	IK	F
1/9/94	Th	1244	IK	F
10/11/94	Th	0934	IK	F
17/11/94	Th	0500	IK	F
17/11/94	Th	?	IK	F
28/1/95	Sa	1739	I	E
11/2/95	Sa	0928	IK	F
3/3/95	F	0723	IK	F
25/11/95	Sa	2014	I	E
22/12/95	F	1853	No information	No information
20/1/96	Sa	1446	No information	No information
8/3/96	F	1204	No information	No information

Code

Location of fire		Supposed cause of fire	
I	Indoors	U	Unknown
O	Outside	H	Human
K	Kitchen	R	Resident
D	Dormitory	S	Staff
L	Laundry	E	Electrical fault
		C	Cigarette, lighter or matches
		F	Burning food

SUMMARY

Year	Number of MFB attendances	Fires involving human , element, and cigarettes lighters or matches	Kitchen fires involving burnt food
1985	8	3	0
1986	4	1	0
1987	4	2	1
1988	5 (+2 for the same fire)	4	0
1989	2	0	0
1990	2	0	0
1991	1	0	0
1992	0	0	0
1993	14	0	11
1994	16	1	12
1995	5		2
1996	2		
TOTAL	63(+2)	11	26

APPENDIX 2.8

VILLAMANTA LEGAL SERVICE – CHRONOLOGY OF EVENTS ABOUT CIRCUIT 39

Date/time	Event	Ref:
Mar 93	Renovations 30/31 Stage 1 partitions flat E Unit 31 Extension of flat E constructed by Michaud Constructions Certified by Croyden Council (# 195 – Bathrooms refurbished and additional bedrooms built by extending patio and decking area in U 31)	McCartin statement # FPM 10
Apr – May 93	FFE installed 5 smoke detectors in U 30 3 in area now known as Flat A 1 near Door 51 (does not exist at time of fire) 1 in corridor outside Door 49 (does not exist at time of fire) 1 in living area of Flat A near Door 49 (does not exist at time of fire) 2 in area now known as Flat B 1 in corridor of Flat B near Doors 36 & 33 (does not exist at time of fire) 1 in living area of Flat B between door 60 and door 29 (does not exist at time of fire)	Srini Vasan para 9 # SV4
10 Jun 93	False alarm code 67 accidental operation of alarm alarm activated by workman – Profile Renovation, factory 4, 2 Caser Drive, Rowville 3178 c39 reported to Jonkar	False alarm 69907 # 19
11 Jun 93	False alarm code 69 simulated condition dust in vicinity of smoke detector activated same C 39 not reported to anyone	False Alarm No 69909 #19
18 Jun 93	False alarm code 69 simulated condition workman in area. Failure to isolate alarm Michaud Constructions / Profile Constructions c39/40 reported to Vasan	False report no 69920 # 19
22 Jun 93	False alarm Code 81 Fault in detector Smoke detector operated C39	False Report 69924 # 19
15 July 93	Stephen Moor called out to KRS to repair a fault in a smoke detector in circuit 39 head missing replaces head with new head Moore says it was above a bed.	L Neicho para 28 # LJN 21 S&FI* 0703 Moore 8
15 July 93	False alarm Code 80 System malfunction unidentified cause of alarm operation. Indicated c40 (unit 3) no detector indicated as having operated C 40 not reported	False alarm 56305 # 19

18 Jul 93	False alarm Code 69 Simulated condition heat from cooking appliance Placed too near a thermal detector. relocation of either would be advisable c 39 not reported	False alarm 69938 # 19
19 Jul 93	False alarm 16.01 pm code 81 fault in detector heat detector too close to heat supply C 40 reported to main desk	False alarm 69941 # 19
20 Jul 93	False alarm code 81 fault in detector heat detector too close to heat supply Not the same as call 2186 c 39 Reported to main desk	False Alarm 69942 # 19
24 Jul 93	False alarm code 69 simulated condition renovating taking place in units 30-31 circuit isolated until work completed c 39 reported to 4444 R.S	False Alarm report 56306 # 19
26 Jul 93	False Alarm code 67 Accidental operation of alarm Technician Skye of Jonkar. Isolate wrong circuit whilst testing alarms Smoke detectors being tested? C 40 reported to Jonkar	False alarm 69948 # 19
2 Sept 93	False alarm code 69 simulated condition workman in units 30/31 digging up concrete floor creating dust which activated the detector c39 not reported	False alarm 56342 # 19
3 Sept 93	Stephen Moore attends KRS in response to alarm S&FI 0719 illegible but concerns U 30/31	L. Neicho para 28 # LJN 21 S&FI 0719 # LJN 22 Invoice 1341
29/9/93	Jonkar install 10 smoke in flat E Jan Plan refs: 39/16 to 39/25	L. Neicho # LJN 23 # LJN 22 Invoice 1393 Sketch plan of Stephen Moore # 200 SJM 2
Nov 93	Renovations approved Unit 30 by O'Flynn creates 2 flats & extension of bedrooms certified by Croyden Council Unit 30 by Asset Services bathroom, bedroom & kitchen Certified by Croyden Council	McCartin statement FPM 10
Renovations commence		

Feb – Mar 93	Jonkar install 5 Hochiki SLK-A photoelectric smoke detectors in flat B (Jonkar contracted by Flat B renovator for this) Hochiki Type DCA in Flat D area at position 39/7 on Jan plan	Neicho 30
20 Jan 94	False alarm code 80 system malfunction workman in U 31 which is under renovation. May be the cause, maintenance company contacted immediately to reinstate circuit C 39 reported to the Boss	False Alarm 76725 # 19
20 Jan 94	Jonkar attend 30/31 in response to false alarms on circuits 39 caused by construction work Moore says he attended 30 because smoke detector locked in alarm 1 thermal installed until construction work finished	L Neicho para 31 # LJN 21 S&FI 0527 # LJN 22 Invoice 001431 Moore 12
26 Jan 94	False alarm code 69 simulated condition Building renovations being done in Unit 30. Note: no building activity at time of call. Large amounts of ?/dust accumulated due to works. Strong winds travelling through opening probably cause detector to be activated c 30/31?? not reported	False alarm 76733 # 19
26 Jan 94	Jonkar attend 30/31 in response to false alarms on circuits 39 caused by construction work Moore says he attended 30 construction work replaces 5 smoke with thermal until construction finished	L. Neicho 31 # LJN 21 S&FI 0531 # LJN 22 Invoice 001431 Moore 13
Feb / Mar 94	Jonkar install 5 smoke detectors for builder O'Flynn in Flat B	L. Neicho 3 LJN 22 Invoice 001446
2 Apr 94	False alarm code 69 simulated condition smoke from BBQ set off smoke detector in U 31 C39 not reported	False report 79550 # 19
? 94	ULA recommends that the continued introduction of smoke detectors should stop – is ad hoc	Vasan 10
25 Jul 94	False alarm Code 86? Spray ? from shower created alarm and alarm reset C 40 thermal smoke?? Not reported	Call no: 8951 # 19
29 Oct 94	False alarm code 67 ? Staff having barbeque outside building left open door. Smoke set off detector in hall entrance. Staff then moved barbeque and closed door . alarm reset C39 smoke detector	Call no 3980 # 19

1 Nov 94	False alarm code 86 workers having BBQ left door open. smoke entered building and set off alarm C 39 smoke detector	Call no 73 # 19
6 Nov 94 11.22 am	False alarm Code 81 MFB found detector operating in bedroom. People had been present in room but no explanation forthcoming. Possibly fault in detector – unit 30/31, 2nd bedroom on left. Kenny England's room c 39 smoke detector	Call no 625 # 19
6 Nov 94 4.59pm	False alarm Code 81 MFB found same detector operating as before. Alarm reset. But has been isolated. Staff notified 000 notices on MCP. Jonkar to attend immediately c 39 smoke detector	Call no 764 # 19
6 Nov 94	L. Neicho attends 30/31 to replace faulty smoke detector Flat B area	L. Neicho 32 # LJN 21 S&FI 1226 # LJN 22 Invoice 1560
26 Feb 95	False alarm code 80 aerosol spray used near smoke detector c 39 BGA & thermal ???	Call no 3272 # 19
May 95	Renovations unit 31 Stage 2 bathroom renovations Flat E C D Unit 31 vacated for renovations	McCartin statement FPM 10
24 May 95	Skye Neicho attends 30/31 false alarm on circuit 39 replaces 2 smoke with thermal detectors Jan plan 39/35 & 39/39 S. Neicho challenged that it took place in Flat B because the construction work was in Flat E at time	S. Neicho para 7 # LJN 21 S&FI 0565 # LJN 22 Invoice 1667 [3834]
26 May 95 9.45pm	False alarm steam activated smoke detectors. Shower left on. c 39 smoke detector	Call no 2518 # 19
2 June 95	3 domestic smoke alarms installed in 30-31 directed to by Gary Radler (manager of KRS) McCartin indicates this was to occur when renovations were taking place	Vasan 16 [1206]
23 Jun 95	Skye Neicho & S. Moore attend Flat E bedroom converted to bathroom concrete dust generated & set off alarm new concrete slab laid & prevented access to detector Circuit 39 isolated overnight	S. Neicho para 8

24 June 95	Moore from Jonkars attends 31 "Reported from previous call ???? Detector locked in alarm. Gained access to detector cleaned & adjusted detector. To reset. Reset detector. CCT clear, tested CCT, de-isolated CCT 39" replaces smoke detector with thermal detector Jan plan ref 39/21	Moore 14 LJN 21 S& FI 0892 LJN 22 Invoice 001668 [4048]
26 Jun 95 4.04 pm	False alarm Code 80 when arrival found detector operating in u 30/31. Room was unoccupied. Detector operating correctly. Unknown as to why it operated. Alarm reset c39 smoke / thermal	Call no 2700 # 19
26 Jun 95 5pm	False alarm code 81 upon arrival found detector in unit 31 (same detector as previous call) this circuit isolated. Jonkar notified via comm. centre to attend immediately due to patients in ward units 30/31 smoke /thermal	Call no 2704 # 19
26 June 95	Skye Neicho attends U30/31 false alarm on circuit 39 located a detector which had become full of dust due to renovation works in flat B replaced smoke detector with a thermal detector – Hockiki type A thermal no map reference given for this challenged that this was in Flat B	S Neicho para 9 LJN 21 S&FI 0894 LJN 22 Invoice 1704 [3847 – 9]
10 July 95	Annual test of 30/31	# LJN 18 No 8451
August 95 to November	Renovations Kitchen Flat E & C	McCartin statement FPM 10
Oct 95	Vasan observes smoke detector above kitchen bench in Flat E inappropriately placed asks Jonkar to attend	Vasan 17
2 November 95	Jonkar attend to detector in Flat E Vasan understands it was replaced with thermal other detector in lounge area of Flat E replaced with thermal at this time smoke detector removed-used to replace an existing heat detector in flat D bedroom Jonkar says Moor e of their office attended as he was requested to check whether the fire detectors in new flat E "conformed with Code" Moore replaced 2 smoke detectors in kitchen with Hochiki thermals Jan plan refs 39/8 & 39/19 Moore used one of the displaced smoke detectors to replace a therm al detector in position 39/7 of D Flat Moore says smoke detectors in all bedrooms in flat E Positions 39/17, 39/22, 39/23 & 39/25 smoke detectors still in place in kitchen area replaces these with thermal 39/8, 39/39/19 used one smoke detector to replace thermal in D Flat, 39/7	Vasan 17 Neicho 36 LJN 22 Invoice 001774 Moore 16

3 Jan 96	False alarm at 30/31 Jonkar attend – Moore, Skye Neicho & Travis Cox located smoke detector in corridor in flat E area (position 39/20) as being activated by steam replaced with thermal	Neicho 37 LJN 21 S&FI 0988 Moore 17
15 Jan 96	Wormalds commence work in 30-31	Mitchell 24 Vasan 23
24 Jan 96	False alarm Air conditioning installation	AHCOT book #95 Unit Communications Book Transcript 5/3/96
24 Feb 96	False Alarm faulty thermal detector	Transcript 5/3/96 AHCOT Book # 95
2 Apr 96	Cox from Jonkar performs monthly test on fire safety system but not Wormalds equipment	Cox 8 9

APPENDIX 3 RECOMMENDATIONS OF PARTIES ON FIRE SAFETY '*A PRESCRIPTION FOR PREVENTION*'

3.1 Introduction to Appendix 3

3.2 The '*model*' system – The State of Victoria (and the Department of Human Services) Recommendations

3.3 '*A prescription for prevention*'– The Metropolitan Fire Brigades Board (Department of Justice) Recommendations

3.4 BSA's Vision – A Systems Approach – The Building Services Agency (Department of Infrastructure) Recommendations

3.5 Umow Lai & Associates Pty Ltd Recommendations

3.6 Wormald Fire Systems Recommendations

3.7 Villamanta Legal Service Recommendations

3.8 The Office of the Public Advocate Recommendations

3.9 The Health and Community Services Union Recommendations

3.10 The Kew Cottages & St. Nicholas Parents' Association Recommendations

APPENDIX 3.1 INTRODUCTION TO APPENDIX 3

The documents contained in Appendix 3 are the recommendations of a number of parties who were involved in the inquest. A reading of the recommendations demonstrates that a considerable amount of reflective work has been undertaken by many of the parties to ensure that fire safety lessons are learnt by our society.

The lessons span both safety at KRS and broader fire safety applying to both public and private buildings. It is essential that the appropriate experts give due consideration to each of the recommendations contained in this Appendix.

APPENDIX 3.2 THE '*MODEL*' SYSTEM – THE STATE OF VICTORIA (AND THE DEPARTMENT OF HUMAN SERVICES) RECOMMENDATIONS

1. INTRODUCTION

1.1 The State of Victoria recognises that the Coronial Inquiry into the fire and deaths of nine clients at Kew Residential Services ("KRS") on 8 April 1996 has focussed very much upon identifying deficiencies and solutions to rectify those deficiencies. The approach of the State Coroner in concentrating upon the lessons to be learned from the tragedy is one supported by the State of Victoria. The State of Victoria has demonstrated it is prepared to engage meaningfully in this process by setting in place a system of reform before the conclusion of the Inquest. The reform will be continuing as review procedures are embedded into the system. The reform will not however be limited to KRS, but will extend to other forms of accommodation provided by the Department of Human Services ("DHS") and non-government organisations funded by DHS.

1.2 The Department of Human Services will ensure that the "lessons learnt" through the fire, the subsequent investigation and the Coronial Inquest are disseminated and critically examined by all relevant program areas of the Department. As outlined elsewhere in this submission, the Department has demonstrated its willingness to embrace reform in all areas which affect fire safety. To ensure that these matters are considered by all relevant Divisions of the Department the following strategies will be adopted:

(a) Francene McCartin, Manager, Kew Residential Services, will undertake a series of presentations to key management groups such as Regional Directors and Client Services Managers within the Department.

These presentations will outline the issues facing the Department's services regarding fire safety, and present the approaches adopted at KRS and best practice models from KRS and other Departmental Training centres and regions.

(b) A full and comprehensive briefing on the Inquest and the lessons learnt will be provided to the Departmental Executive.

(c) The improvements made at KRS and the statewide initiatives developed by Disability Services will be provided to all other Divisions which provide or purchase accommodation. The findings and recommendations handed down in the Inquest and the Departmental response to the findings will also be provided to these Divisions for consideration and where appropriate, implementation. In this respect the Department notes that the improvements made through the Fire Risk Management Strategy will provide a framework through which these matters can be distributed.

(d) Disability Services has recently developed a Quality Services Framework. The Implementation Plan currently being developed will include references to adhering to fire safety requirements.

1.3 The State of Victoria, in this section of its submission, will elaborate upon the areas of reform that have been undertaken or are in the process of being undertaken.

1.4 The following is a summary of the reforms that have been undertaken, which will be expanded upon later in this submission.

1.5 The Department of Human Services has developed a Fire Risk Management Strategy for all facilities for which the Department has a responsibility. A series of guidelines on fire risk management will be developed and which will form the basis of the strategy (paragraphs 2.1-2.6).

1.6 An amount of $75.5 million has been made available by the government to continue the program of fire safety audits and works to upgrade Department facilities over the next three years (paragraph 2.8).

1.7 The Fire Safety Management Strategy will focus upon fire safety training of all staff and building occupants, including evacuation drills and fire safety manuals (paragraph 2.13).

1.8 A Fire Risk Management Strategy committee will be formed to overview the implementation of the strategy (paragraphs 2.14-2.17).

1.9 Within Disability Services, DHS, in addition to KRS, three of the six training centres have undertaken fire safety audits and fire safety upgrades have either been completed or will be completed shortly. The Janefield and Kingsbury training centres are in the process of closing the old institutional buildings, with most clients moving into the community or into the new Plenty Residential Services facilities which will be completed in approximately August 1997 (paragraphs 2.18-2.20).

1.10 Mental Health Services are progressively being redeveloped across the state, involving the closure of all psychiatric institutions. Fire safety issues are and will continue to be addressed as part of the redevelopment process (paragraph 2.21).

1.11 The Aged Care/Extended Care centres have undertaken some urgent fire safety works at two centres. The Metropolitan Health Care Service's plan will address the fire safety needs of the Metropolitan Extended Care Centres. Rural Extended Care Centres will meet fire safety standards (paragraphs 2.22-2.23).

1.12 The Juvenile Justice Centres are being redeveloped to provide more appropriate facilities and will incorporate appropriate fire safety standards (paragraph 2.24).

1.13 The Office of Housing has developed a range of plans to assist with emergencies. These include the Response and Recovery Plan and the Municipal Emergency Plan. An order program to assess fire safety standards will be conducted on all estates this year. A fire awareness video was produced on the Kensington estate in late 1996 and it will form the pilot for a video to be distributed to all estates (paragraphs 2.25-2.27).

1.14 As part of a government initiative, the Office of Housing has commenced a program of hardwired smoke detector installation in all public housing units (paragraph 2.29).

1.15 The Office of Housing, the MFB and the SES met on 4 March 1997 to develop a risk assessment program of the high rise and associated walk-up buildings for the safety of current and future clients in terms of fire and other emergencies. The program will comply with AS4360, the new Australian standard for risk assessment programs (paragraph 2.30).

1.16 In respect of the non-government sector agencies, the Department is requesting all funded agencies, through the Funding and Service Agreement process, to ensure that the accommodation provided for and used by

clients of the Department meets all the legislative requirements for fire safety standards and occupational health and safety. The Department will require all agencies to comply with the guidelines outlined previously (paragraph 2.31).

1.17 The Minister for Youth and Community Services has requested fire safety assessments and audits on 27 non-government organisation congregate care facilities for people with an intellectual disability funded by the Department (paragraph 2.32).

1.18 The Department has established a registry of fire engineers for audits and fire risk analysis (paragraph 2.33).

1.19 An additional clause requiring the fire engineer to identify, design, document, tender and administer the contract of interim works has been included in the standard fire safety audit and fire risk analysis consultant's brief (paragraph 2.38).

1.20 Professional groups are developing competency requirements determining adequate levels of experience and standards of education for people working on and maintaining fire safety systems (paragraph 2.39).

1.21 A brief is currently being developed for the tender of a consultancy for a qualified fire engineer to provide on-call advisory services to all DHS training centres (paragraph 2.47).

1.22 Warrington Fire Research has been engaged to review the existing fire safety systems at KRS and make any recommendations for additional works within three months (paragraph 2.48).

1.23 In relation to clients at KRS a comprehensive approach to firelighting behaviour has been co-ordinated by the Eastern Metropolitan Specialist Services Team. All clients with suspected firelighting behaviour are referred to the Eastern Metropolitan Fire Risk Action Group for the development of appropriate strategies (paragraph 3.3).

1.24 The Disability Services Branch has implemented a detailed policy statement for the assessment and management of fire risk behaviours in clients with an intellectual disability (paragraph 3.5).

1.25 An expanded Assessment of Needs Report has been developed which includes prompts for case managers to better assess a client's firelighting risk (paragraph 3.9-3.12).

1.26 A Disability Services kit has been developed containing information designed to be provided to families who have a family member with an intellectual disability living at home with the emphasis upon the prevention and management of firelighting behaviour (paragraphs 3.13-3.16).

1.27 A training manual and video for staff working in community residential units, together with implementing a series of training seminars intended to provide practical awareness of fire risk and appropriate evacuation training (paragraphs 4.1-4.10).

1.28 The Disability Services Training Unit has included specific information on fire risk behaviour in training courses for BIST workers and in the orientation training provided for residential workers (paragraphs 4.11-4.14).

1.29 There will be installed in Unit 7/8 at KRS full sprinklering (section 5).

1.30 Schematic plans for the whole of KRS, in the MFB recommended format, have now been produced. All training centres and community based accommodation will now be required to produce similar floor plans (section 6).

1.31 Evacuation packs containing information and appropriate items have now been developed and placed at the fire panel in each unit at KRS. All training centres and community residential units will be issued with evacuation packs (section 7).

1.31 The KRS Fire Safety committee was reconvened in July 1996 and has met bi-monthly since that time. All Disability Services training centres will be required to establish a Fire Safety committee comprising both direct care and non-direct care staff (section 8).

1.32 To facilitate consultation with the MFB, a KRS/MFB Liaison committee was established. It is intended that all training centres will set up a similar liaison structure with the local MFB or CFA (section 9).

1.33 KRS has established a requirement that units must complete six drills per annum including at least two night drills. The drills will be evaluated by a Unit Manager from another unit, using the Fire Drill and False Alarm Evaluation Form. A process to analyse the Evaluation Forms has been put into place (section 10).

1.34 A comprehensive fire safety and response training program has been put into place, including a system of refresher training. Advanced fire safety training and fire warden training has been provided. The orientation/ induction training for new staff includes fire safety and evacuation training. Fire safety and response training is now mandatory on a statewide basis (section 11).

1.35 The client lists have been reviewed as a result of which a master list of each unit will now be produced and kept in the evacuation pack and at the administration building, and a whereabouts list will be kept at the exit to each unit during the day and in the evacuation pack at night. Such practices will become mandatory at all Disability Services training centres (section 12).

1.36 The fire safety manual, developed in consultation with the MFB, is now in force at KRS. It will be constantly reviewed for improvement. A standard fire safety manual, based on the KRS fire safety manual, will be developed for all training centres and community based accommodation in consultation with the MFB (section 13).

1.37 The KRS policy and procedure manual has been reviewed and an easy reference index guide provided. Procedures have been improved to ensure staff read the manual and any updates, including during staff induction (section 14).

1.38 Reflective road tracking to identify from the roads and lanes the location of water hydrants has been installed at KRS, and will be introduced at all training centres where appropriate (section 15).

1.39 A number of minor works initiatives to improve fire safety are being undertaken, including a single master key system (section 16).

1.40 The monitoring of false alarms will be an ongoing agenda item at the KRS/MFB Liaison committee meetings (section 17).

1.41 The unit meetings agenda and minuting of meetings has been reviewed and a number of improvements made (section 18).

1.42 The existing management quality assurance systems checklist has been supplemented by two new checklists, being a management quality audit including general fire safety issues, and a night services checklist (section 19).

1.43 As from 1 March 1997 the management of all non-direct care services at KRS transferred to the Manager. All regions will be required to put in place a structure which ensures local co-ordination of fire safety issues (section 20).

1.44 A new handover format has been introduced including references to fire safety and the handover time has been extended to 15 minutes at the beginning and end of each shift for all units (section 21).

1.45 In the area of GSP/IPP staff awareness, a number of initiatives have been put into place including:

- Assessment of Needs and GSP training for Unit Managers and Deputy Unit Managers;
- complete revision of the key worker system, with an emphasis on staff roles and responsibilities in relation to IPPs;
- discussion of an individual client's IPP at the monthly unit meeting;
- quality control mechanisms including a "bring up" system to ensure GSPs are completed on time; and
- random audits of client files. The file audit includes checks on the current GSP and IPP, as well as the appropriate location of other reports (section 22).

1.46 Record keeping has been improved with the introduction of the new style of the Accommodation Services file and the new Disability Services Client Information System (section 23).

1.47 The client alert system can now be reassessed and updated regularly due to the introduction of the new Disability Services Client Information System (section 24).

1.48 Staff have been informed that where any client is involved in any incident related to firelighting behaviour an incident report should be completed (section 25).

2. FIRE RISK MANAGEMENT STRATEGY

A. OVERVIEW

2.1 The State of Victoria is committed to providing safe and secure buildings for all DHS owned and operated facilities, as part of its service provision mandate. A critical component of this commitment is the development of a Fire Risk Management Strategy for all facilities for which the Department has a responsibility.

2.2 All departmental buildings complied with the relevant regulations current at the time of their construction. However, improved fire and safety standards are now required to meet the present regulations.

(a) Guidelines on fire risk management

2.3 The Department has engaged consultants to develop principles on fire risk management in Department facilities. The consultants will develop a series of guidelines on fire risk management which will form the basis of the strategy. The guidelines will address each type of client accommodation provided by the Department. Each guideline will be developed with input from the relevant Divisions.

2.4 It is anticipated that the guidelines will cover the following topics:

- General Principles;
- Fire Safety Risk Assessment Guidelines;
- Fire Statistics Review;
- Supported Community Based Houses;
- Congregate Care Facilities;
- Detention and Correctional Facilities;
- Hospitals and Day Centre;
- Rental, General and Other Housing.

2.5 The first guideline to be completed and endorsed was the Guideline for Fire Risk Management in Supported Community Based Houses, May 1997 (Appendix A). All the guidelines are programmed for completion by September 1997. The guidelines will be reviewed to take into account the findings and recommendations that may be made in this Inquest.

2.6 The previous standard for the Department's Supported Community Based houses recommended hard wired smoke alarms and earth leakage devices. In addition, where the evacuation time exceeds 3 minutes, the new guidelines require sprinklers to be installed in these houses. Disability Services, DHS, has also prepared a video in conjunction with the MFB on fire awareness and evacuation procedures from domestic housing (see section 4A).

(b) Fire safety audits and fire safety upgrades

2.7 A program of fire safety audits has been in place since 1993, initially targeting the major metropolitan hospitals, aged care centres and the intellectual disability training centres. A program of fire risk assessments and consequent priority works to upgrade all public health care and departmental facilities is currently being implemented and is scheduled for completion in the year 2000. These audits and works will bring all these facilities to an appropriate standard of fire safety. In addition, current major facility redevelopments will also incorporate fire safety works.

(i) Funding

2.8 The program of fire safety audits and works to upgrade the facilities over the next four years has been prepared with an indicative cost for audits and works of $125 million. The Government has made available $75.5 million for this process, which was announced in the 1997/98 budget. The funds are available over the next three years for the progressive upgrade of fire safety for Department owned or operated buildings. The audits are targeting both metropolitan and rural services, with the identified high and medium priority works progressively implemented across the State.

(ii) NGO

2.9 Non-Government owned ("NGO") congregate care client accommodations are to be included in the Fire Risk Management Strategy. NGOs will be funded by the Department to carry out fire safety audits and fire risk analysis by qualified fire engineers in accordance with Department guidelines. The installation of smoke detectors and earth leakage devices are a Department requirement advised in Information Circular 12/1994.

(iii) Non-housing facilities

2.10 The Department's Fire Risk Management Strategy for non-housing facilities includes, as a first step, the implementation of fire safety audits by qualified fire engineers to assess fire risk. The objective of the audits is to determine the high, medium and low priority works necessary to bring the buildings to a standard which

will minimise fire risk and provide a fire safe environment. The fire engineers will be required to identify interim works and provide specifications for undertaking the works ahead of works identified on the priority listing.

2.11 The high priority and medium priority works are undertaken with assistance from the Capital Works program, and the low priority works, which generally require a facility specific management response, are the responsibility of the particular Network, institution or agency.

(iv) Rural hospitals

2.12 Small rural hospitals generally reflect the standard of fire safety features at the time they were built. The Government's Small Rural Hospitals Task Force Report reviewed the mix of care provided and the viability of these hospitals. The outcome has been that many of these hospitals have commenced redevelopment programs to provide a range of integrated health services to better meet the needs of the local rural communities. Fire safety issues will be addressed as part of these redevelopments. Fire safety audits will also be undertaken progressively throughout the State for the small rural hospitals.

(c) Fire safety training

2.13 In addition to the program of fire safety works, the Fire Safety Management Strategy will encompass the following:

- Fire safety training of all staff and building occupants is considered to be critical for maintaining a fire
- safe environment.
- A program of evacuation drills practised on a regular basis is to be developed for each building.
- To ensure a co-ordinated approach to fire safety, local manuals will be required. Examples will be
- made available to agencies to streamline development and production time lines.
- Fire safety training, evacuation drills and fire manuals are the responsibility of each program/institution/ agency and should be tailored for their specific requirements.

A series of recently completed reviews of fire safety systems installations will be conducted by qualified fire engineers in 1997. This program will be extended to cover a sample of building types for each Program.

(d) Fire Risk Management Strategy Committee – Implementation

2.14 A Fire Risk Management Strategy Committee will be formed with representation from each Division and from one of the metropolitan and rural regions to overview the implementation of the strategy and report to the executive of the Department. The Committee will finalise and endorse the remaining guidelines by September. The Committee will be supported by Capital Management Branch, DHS, which will facilitate implementation of the strategy, engage consultants and contractors for departmental facilities, provide advisory services on fire risk matters, maintain a central database of facilities, audits and works and monitor compliance with the guidelines.

2.15 Regional Directors have been requested to nominate a person responsible for the implementation of the strategy within each Region. That person will be a member of senior management. Within each Region there will also be a steering committee which will oversee all audits and the implementation of interim and high priority works. The regional nominee will provide regular contact for implementation planning, reviewing and recording compliance with the guidelines and advising on issues to be addressed.

2.16 A staff training program for the strategy will be developed by the Human Resources Branch of the Department's Corporate Resources Division. Funding will be identified against the central Staff Development Fund.

2.17 The DHS Fire Risk Management Strategy has been endorsed by the Secretary and distributed to Ministers and Program Directors. The Capital Management Branch has made a presentation, including an explanation of the strategy, in all DHS Regions. A similar presentation to each Program area is currently being planned. A presentation to Regional Directors is planned to fully brief the Directors on the Fire Risk Management Strategy and implementation process.

B. DISABILITY SERVICES, DHS

2.18 Within Disability Services, DHS, three of the six training centres (in addition to KRS) have undertaken audits to assess fire safety standards. Fire safety upgrade works including the installation of residential sprinklers, were completed at Sandhurst (Bendigo) and Pleasant Creek (Stawell) in December 1996. A fire safety upgrade of Colanda (Colac) will be completed later this year.

2.19 The Janefield and Kingsbury Training Centres (Bundoora) are in the process of closing the old institutional buildings. The majority of the clients have moved into housing in the community or will move into the new Plenty Residential Services facilities which is presently under construction and will be completed by the end of August 1997.

2.20 Disability Services will also provide funding to non-government accommodation services to assist those services to meet the requirements of the new Department Guidelines on fire risk management.

C. AGED COMMUNITY AND MENTAL HEALTH DIVISION

2.21 Mental Health Services are progressively being redeveloped across the State, involving the closure of all psychiatric institutions. The redevelopment includes co-location with Acute Hospitals and construction of other facilities in the community. Fire safety issues are being and will continue to be addressed as part of the redevelopment process.

2.22 The Aged Care/Extended Care Centres have undertaken some urgent fire safety works at two centres (Kingston Centre, Cheltenham, and the North West Hospital, Parkville campus). All the metropolitan Extended Care Centres are now part of the Health Care Networks and their fire safety needs will be addressed through the Metropolitan Health Care Services Plan.

2.23 A large number of nursing home beds currently on Extended Care Centre sites will be redeveloped by the private sector and the old buildings demolished. Rural Extended Care Centres will meet fire safety standards, either in the existing buildings or as the health care centre redevelopments take place at Bendigo, Ballarat, Warrnambool and other rural centres.

D. YOUTH AND FAMILY SERVICES DIVISION

2.24 The Juvenile Justice Centres are being redeveloped to provide more appropriate facilities for the range of young persons who require these services. The Malmsbury Centre redevelopment is currently in construction and fire safety is being addressed as part of this redevelopment. The Melbourne and Parkville Centres have completed fire safety works in the current buildings, and the new facilities being planned will incorporate appropriate fire safety requirements.

E. OFFICE OF HOUSING

2.25 The Office of Housing has developed a range of plans to assist with emergencies. These include a Response and Recovery Plan developed with assistance from the Victoria Police, MFB and the State Emergency Service (SES). Response and Recovery Plan exercises have been carried out at six high rise estates in the past 20 months.

2.26 There are also Municipal Emergency Plans which list high rise estates in the relevant municipal plans as a hazard or risk, with the appropriate contacts established for dealing with an emergency. An emergency procedure, known as Tactical Exercise Without Tenants, for public housing estates is being prepared in conjunction with the MFB, Police and the SES for testing on three estates.

2.27 An audit program to assess fire safety standards is being conducted on all estates this year. A fire awareness video was produced on the Kensington estate late in 1996. It will form the pilot for a video to be distributed to all estates.

2.28 The Office of Housing has centralised the co-ordination and management of fire services for all public housing. In 1996 consultants were engaged to compile a comprehensive register of the equipment held in multi-tenanted Office of Housing properties. This register is in the process of being validated and the Country Fire Stations in particular are involved in the consultation. There has been improved maintenance of fire equipment, fire alarms and hoses, and Fire Equipment Services (a branch of the MFB) have increased the frequency of inspections of fire hoses.

2.29 As part of a Government initiative, the Office of Housing has commenced a program of hard wired smoke detector installation in all public housing units. This program is nearing completion in the high rise buildings, and is due to be completed across Victoria by March 1998. An amount of $7.8 million has been committed to provide at least one smoke detector in each of the approximately 65,000 Office of Housing properties. The highest priority has been given to their installation in older person's units and to Community Housing properties such as Rooming Houses and Crisis Housing.

2.30 The Office of Housing, the Metropolitan Fire Brigade and the State Emergency Service held a meeting on 4 March 1997 to develop a risk assessment program of the high rise and associated walk up buildings for the safety of current and future clients in terms of fire and other emergencies. This is to include a pilot sprinkler project for both high rise and walk up buildings. The proposal has been presented to the Victoria Police, the

MFB and the SES for consideration. The program will comply with AS 4360, the new Australian standard for risk assessment programs.

F. NON GOVERNMENT ACCOMMODATION SECTOR

2.31 The Non Government sector agencies that receive funding from the Department for providing support and in some cases accommodation services are required to ensure, as responsible service providers, that their buildings comply with relevant building codes and have staff trained to respond appropriately to fire. The "duty of care" responsibility rests with the management of each agency that owns or leases the buildings used by clients and staff. The Department is requesting all funded agencies, through the Funding and Service Agreement process, to ensure that the accommodation provided for and used by clients of the Department meets all the legislative requirements for fire safety standards and Occupational Health and Safety. The Department will require all agencies to comply with the guidelines developed as part of the Fire Risk Management Strategy.

2.32 The Minister for Youth and Community Services has requested fire safety assessments and audits on 27 non-government owned congregate care facilities for the intellectually disabled funded by the Department. Detailed information is not known about the level of fire safety in these facilities as the duty of care and management of each facility is the responsibility of the individual agency. The Minister had directed that these facilities should be part of the departmental audit and upgrade program.

G. REGISTRY OF FIRE ENGINEERS FOR AUDITS AND FIRE RISK ANALYSIS

2.33 The DHS Fire Risk Management Strategy requires fire safety audits and fire risk assessments of all its facilities to be undertaken by qualified fire engineers. From these audits, the Department will address fire safety issues nominated as high priority.

2.34 Timelines for the fire safety audit/risk assessment phase of the Fire Strategy are very tight requiring the completion of all fire safety audits/risk assessments by the end of 1998. In order to meet timelines for the completion of the fire audit/risk assessment phases, it will be necessary to streamline the process of the engagement of fire engineers.

2.35 By a public advertisement placed in "The Age" on 22 February 1997 Expressions of Interest were called for qualified engineers to conduct fire safety audits and fire risk analysis of Department agencies across Victoria. Applicants had to meet the requirements of either the Institute of Engineers Australia or The Australian Fire Safety Practitioners' Accreditation Board to be included in a Registry of Fire Engineers.

2.36 The Department currently has a Registry of nine qualified consultants which may be used on fire audit and risk analysis projects. A minimum of three consultants selected from the Registry will be invited to tender a detailed submission for each fire risk management project or group of projects. A selection and recommendations will then be made from the detailed submissions. The process negates the need to go to a separate tender for each consultancy, and does not require individual expressions of interest or interviews of consultants. It is estimated that the use of the registry to shortlist consultants will save approximately 1 to 2 months in the process of obtaining a fire risk analysis.

2.37 A seminar was presented by the Department to the consultants on the Registry on 16 May 1997 explaining the Fire Risk Management Strategy, Department expectations on its implementation and the categories of use for facilities for which the Department has a responsibility. Program representatives also presented information on the needs of the various client groups for whom the Department is responsible and discussed issues around meeting special needs. A package of information presented at the seminar was distributed to all the consultants.

H. INCLUSION OF AN INTERIM WORKS CLAUSE INTO STANDARD BRIEF

2.38 An additional clause requiring the consultant to identify, design, document, tender and administer the contract of interim works has been included in the standard fire safety audit and fire risk analysis consultants brief. This will allow for urgent work to be commenced within one to two months after the audit report is received.

I. COMPETENCY REQUIREMENTS FOR FIRE PRACTITIONERS

2.39 Professional groups (Institute of Engineers and The Australian Fire Safety Practitioners' Accreditation Board, Inc) are developing competency requirements, determining adequate levels of experience and standards of education for people working on and maintaining fire safety systems. The Department has a representative on the Australian Fire Safety Practitioners' Accreditation Board.

2.40 A new classification of fire engineer is due to come into operation on 11 August 1997. The new category of engineer will be included in Part 15 of the Building Regulations 1994. The qualifications required of fire engineers will be a degree in fire safety engineering and three years experience in the field of fire engineering or registration on the National Professional Engineers Register.

J. MAINTENANCE OF FIRE SAFETY AND SECURITY SYSTEMS AT DHS TRAINING CENTRES

2.41 DHS has commenced the engagement of consultants to prepare a departmental guideline for use in DHS Training Centres. The consultant's brief falls broadly into 4 major phases:

2.42 Phase 1 A review of available material/publications including the Building Control Commission's "Essential Services Maintenance Manual". The preparation of a specification to be used for the calling of:

- tenders from suitable contractors for:
- the maintenance of existing fire safety and security systems in accordance with relevant standards,
- guidelines and codes;
- ensuring the compliance of the existing system to current Australian Standards;
- ensuring that all works are to be undertaken only by accredited installers and suppliers. It is recommended that any person working on the system must hold the appropriate certificate of accreditation from The Australian Fire Safety Practitioners Board Inc or equivalent.

2.43 Phase 2 Determination of appropriate quality control/assurance systems for maintenance of all fire safety and security systems including requirements for independent checking and verifications.

2.44 Phase 3 Development of reporting procedures and formats for annual reports in a management format to be developed by consultants to include but not necessarily limited to:

- exception reports;
- non-compliance reports;
- sign off response;
- routine auditing.

2.45 Phase 4 Development of a suitable contract in accordance with the DHS standard service contract and including:

- reference to all the above;
- fees to be inclusive, ie call out, on call 24 hours a day;
- schedule for urgent and essential works;
- definition of key terms.

2.46 An addendum has been added to the above contract requiring the consultant to apply the guidelines and processes which are developed to the maintenance contract at KRS. This will involve tendering the maintenance contract, monitoring the application of the guideline and the contractors contract for a period of six months, and making any changes to the guideline which may arise during that time. The scope of the additional works at KRS include the following:

- preparation of an advertisement and selection criteria for Expressions of Interest (EOI) from suitable contractors;
- analysis of EOI and recommend shortlist of contractors to provide detailed submissions;
- preparation of a detailed brief for KRS based on the generic guideline including selection criteria;
- analysis of detailed submissions in consultation with representatives of the Agency, Region and Capital Management Branch, and provision of a written report recommending the preferred contractor; monitoring the performance of the fire safety and security systems maintenance contractor for a period of six months from the contractors engagement;

- A review of all relevant documents after the six month monitoring period and recommend any changes required.

2.47 Following evaluation this contract will be considered for use in all Departmental facilities and residences.

K. PROVISION OF ON CALL CONSULTANCY SERVICES FOR FIRE RISK MANAGEMENT FOR DHS TRAINING CENTRES

2.48 A brief is currently being developed for the tender of a consultancy for a qualified fire engineer to provide on call advisory services to all DHS Training Centres. The Training Centres will be able to request advice and consultancy services from the fire engineer on any issue about fire safety on an as needed basis.

L. FIRE ENGINEERING AUDIT AND RISK ANALYSIS OF EXISTING FIRE SAFETY SYSTEMS AT KRS

2.49 Warrington Fire Research Pty Ltd has been engaged to review the existing fire safety systems at KRS and make any recommendations for additional works within three months. This will provide the opportunity to examine the existing systems installed at KRS and to determine their effectiveness and recommend any changes or additional works required to ensure additional safety for the building occupants.

3. FIRELIGHTING BEHAVIOUR

3.1 As the Department acknowledged (exhibit 267) on 9 April 1997, at the time of the fire the approach to assessing and managing clients who were a firelighting risk was not as comprehensive or as expansive as required nor was the approach incorporated into the Department's systems.

3.2 Since 1996 the approach taken by the Department has been broadened. The emphasis of the Department has moved from a response to those individuals with demonstrated firelighting behaviour to focusing on the assessment of potential firelighting behaviour. This necessarily includes a much larger group of people who require proactive strategies to prevent actual instances of firelighting.

3.3 In relation to clients at KRS a comprehensive approach to firelighting behaviour is being co-ordinated by the Eastern Metropolitan Specialist Services Team [T. 6758]. There has been extensive consultation with the MFB Juvenile Fire Awareness Unit and the involvement of Professor Robert Adler from the Royal Children's Hospital. All clients with suspected firelighting behaviour are referred to the Eastern Metropolitan Fire Risk Action Group, which includes a representative from the Juvenile Fire Awareness and Intervention Program, and has access to consultations with Professor Adler. Strategies to address the client's behaviour are outlined in the client's IPP and brought to the attention of all staff.

3.4 The Department has moved to change its systems to embed the appropriate management of firelighting risk into established practices of the Department. The following measures have been implemented:

A. DISABILITY SERVICES POLICY STATEMENT

3.5 The Disability Services Branch of DHS has implemented a detailed policy statement for the assessment and management of fire risk behaviours in clients with an intellectual disability. The statement covers:

- procedures for the assessment of fire risk behaviours by both Client Services workers and Accommodation and Support staff;
- detailed responses to manage both the client's behaviour and the environment once fire risk behaviour has been identified; and
- staff responsibilities in fully and regularly documenting all information on the client's file.

The policy is annexed to the statement of Pam White (PW 5).

3.6 Prior to the development of this statement the only guideline available to staff was a direction from the Secretary of the Department regarding the issue of firelighting behaviour and the need for vigilance in identification and referral to appropriate services.

3.7 In the development of the policy statement and the components covered under the policy, consultations were held with Professor Adler, Regional Client Services staff and representatives from the Juvenile Fire Awareness and Intervention Program. The policy was developed through the following process:

- discussions with regions on current practices and identification of statewide best practice;
- discussions and further consultation with Professor Adler on fire risk and firelighting behaviour;

- discussions with representatives from the Juvenile Fire Awareness and Intervention Program on intervention and environment management;
- a review of client file documentation by a senior Client Services worker;
- inclusion of specific fire risk flags on the new computer client and case management data base; and
- the development of the policy statement and internal review.

3.8 The policy statement and its component parts are a significant improvement on the previous guideline to staff. There is now:

- a recognition of both fire risk and firelighting behaviours;
- a consistent statewide process for the assessment and identification of both these types of behaviours;
- a systematic and detailed hierarchy of responses to these behaviours;
- a consistent statewide process for flagging the presence of these behaviours on the new client and case management data base.

B. ASSESSMENT OF NEEDS REPORT AMENDMENT

3.9 An expanded Assessment of Needs Report has been developed which includes prompts for case managers to better assess a client's firelighting risk. An Assessment of Needs Report is completed for all clients requesting services through Client Services teams. This forms the entry process for the Intellectual Disability Service System. Prior to the introduction of the amended Assessment of Needs Report there was no set assessment process and no consistent approach. Identification rested with individual workers and their awareness of risk behaviours. There was also no systemic structure to the recording of the information if identified as a risk.

3.10 The amendment includes a set of questions in the Report specifically designed to assess for both fire risk behaviour and firelighting behaviour. The additional Assessment of Needs Report questions cover in detail fire risk in relation to the client's personal care skills, their communication and language skills related to danger, their cognitive and adaptive abilities, domestic skills and any issues related to their living situation and health. The gathering, analysis, response and recording of this information has now been standardised and incorporated into the regular duties of staff providing direct services to clients with an intellectual disability. The additional prompts include the following:

Section 2:
Personal care skills ... Is the client able to implement safety/evacuation procedures related to fires or similar emergencies?
Communication and language skills ... What is the client's ability to communicate they are in danger?
Cognitive/adaptive abilities ... Does the client have an awareness of fire? Is the client's attention attracted by fire/smoke/heating/cooking appliances? Do the conversations, drawings, play, interests include fire themes? Does the client understand the danger or consequences of fire, including the danger/consequences to self/ others?

Domestic skills ... Is the client aware of the uses of fire/heating and cooking appliances? Can the client use appliances safely/appropriately?

Section 3:
Living situation ... Does the client have access to fire or flammable items (eg. candles, matches, lighters, flammables, clothes, paper, heaters, stoves, etc)? Also consider for other settings, eg. vacation, school, leisure etc.

Health ... Does the client have any conditions, eg. illness, medication, alcohol use, physical or sensory disability, etc., that could impair the capacity to act safely or respond to an emergency?"

3.11 The questions are also provided in a questionnaire for Accommodation and Support staff to assess clients who are already living in Departmental residential services or supported by outreach staff. A copy of the questionnaire is annexed to the statement of Pam White (PW 5). This ensures a consistent statewide approach to the assessment of clients to identify these behaviours. The results of these amendments will be recorded on the client's file.

3.12 In developing the Assessment of Needs Report questions, consultations were held with Professor Adler and Regional Client Services staff. Draft assessment questions were provided to Professor Adler, and his recommended further additions were incorporated.

C. DISABILITY SERVICES KIT

3.13 The Disability Services kit is a collection of information designed to be provided to families who have a family member with an intellectual disability living at home. A copy of the kit is annexed to the statement of Pam White (PW 7). The kit highlights the risks, preventative strategies and responses to fire in the home. The kit is provided to families when they approach Client Services teams. The kit includes:

- a list of tips and precautions related to fire prevention;
- a sheet of information/instructions concerning "what to do if a fire should occur ...";
- information and a listing of "where to go for help if you have any concerns about fire ...";
- a listing of names, addresses and phone numbers of local authorities and groups that register where advice and assistance can be obtained. These included: JFAIP, MFB, CFA, Police, SES, Disability Services (head office), Ambulance Service, Gas & Fuel Corporation;
- emergency telephone numbers;
- a pro forma for a home safety evacuation plan;
- an illustrated instruction sheet of "what to do if anyone's clothes catch on fire ..." including Stop, Drop & Roll method;
- a sketch of a room containing furniture and explanations of items which would become sources of toxic gases in event of a fire;
- a pamphlet on smoke alarms.

3.14 In developing the Disability Services kit there was detailed consultation with representatives from the Juvenile Fire Awareness and Intervention Program. They were provided with a draft copy of the information and their comments were sought regarding the comprehensiveness and appropriateness of the information. Much of the information included in the kit was sourced from the Juvenile Fire Awareness and Intervention Program.

3.15 Prior to the development of the Disability Services kit the information provided may not have been sufficiently comprehensive to allow families to consider all strategies necessary to manage their family member's at risk behaviour. The provision of information to families caring for a person with an intellectual disability would have relied on the thoroughness of individual case workers. The availability of the kit ensures that the issue of fire risk and suggested ways to minimise it are available in an accessible and consistent format. In this context case workers are more likely to address the issue and when it is addressed it will be done so in a consistent manner.

4. FIRE SAFETY IN COMMUNITY RESIDENTIAL UNITS

A. FIRE SAFETY TRAINING PROGRAM AND VIDEO

4.1 The Disability Services Branch of DHS engaged the MFB to produce a training manual and video for staff working in community residential units. The Disability Services Training Unit (DSTU) provided significant input into the training aspects of the manual and video. A copy of the manual was produced to the Inquest as annexure "PW 4" to the statement of Pam White.

4.2 The manual and video has been distributed to both government and non-government services providers.

4.3 The training package is based on self-paced learning with all direct care staff being required to complete practical exercises relating to their comprehension of the fire safety information contained in the manual.

4.4 Supervisors are required to record that staff have viewed the video and completed the exercises.

4.5 The MFB is conducting a series of training seminars for both Departmental and non-Departmental service providers. The seminars are intended to provide practical awareness of fire risk and appropriate evacuation training.

4.6 The IDS Accommodation Services Emergencies Manual (April 1993) contains procedures for both evacuation planning and evacuation. All Departmental facilities have had copies of this manual since 1993.

4.7 Prior to the release of the package, regions were individually responsible for the development of fire safety training.

4.8 The package was piloted in one Departmental Region (Eastern Metropolitan Region) to ensure that it was comprehensive and could be readily implemented. Minor modifications were made to the package following the pilot.

4.9 The non-government sector expressed interest in the package and following detailed consultation with representatives of that sector regarding their particular needs, DSB made some minor modifications to the video. The package has now been distributed to non-government service providers.

4.10 The release of the package means that there is now:

- consistency in the nature of fire awareness and fire evacuation information disseminated to providers of community based residential services for people with disabilities;
- consistency in the training provided to direct care staff which is portable across the sectors.

B. IMPROVEMENT IN TRAINING SESSIONS BY DSTU

4.11 The DSTU have included specific information on fire risk behaviours in training courses for BIST workers and in the orientation training for residential workers. These two groups of staff have the primary contact with clients living within Disability Services CRUs and residential services.

4.12 Prior to this change there was no consistent reference to fire risk and firelighting behaviour. Reference to these behaviours was dependant on presenter awareness or the interest of those attending the training.

4.13 In developing these items in the training courses meetings were held with:

- staff from DSTU;
- staff from the DSTU in conjunction with Juvenile Fire Awareness and Intervention Program.

4.14 The incorporation of specific information on fire risk and firelighting behaviour results in the consistent and systemic raising of these behaviours with staff most closely involved with the care of clients who may exhibit these behaviours. This makes them aware of potential risk to clients and provides background information on the types of services that can be utilised in managing the behaviours.

5. INSTALLATION OF FULL SPRINKLERING TO UNIT 7/8 AT KRS

5.1 As foreshadowed by Ms McCartin [T. 6750], a fire engineering analysis has been completed of Unit 7/8 at KRS by Warrington Fire Research Pty Ltd. The report has recommended the installation of sprinklers throughout Unit 7/8.

5.2 A consultant appointment is in process to design, document, tender and administer the contract of the installation of sprinklers throughout Unit 7/8.

5.3 In addition to the above, the consultant will be required to engage the services of a Building Surveyor to inspect the site of the installation, review the tender documentation and issue a building permit for the extension of the fire sprinkler system.

5.4 The installation contractor shall also be required to engage an independent registered certifier to certify that the installation has been installed as per the relevant Australian Standards.

5.5 The Minister for Community Services, the Honourable Denis Napthine, has announced that the 2 storey units at KRS will be closed. However this will not affect the timetable for the installation of sprinklers.

6. FLOOR PLANS

6.1 Prior to 8 April 1996, the Metropolitan Fire Brigade was provided with a site plan of Kew Residential Services but no detailed schematic floor plans of the units were available at that time. As an interim measure, KRS produced unit floor plans in the format recommended by the MFB.

6.2 The Public Correctional Enterprise was then contracted by KRS to produce schematic plans for the whole of KRS, again in the MFB recommended format. These plans were completed in April 1997 and were produced to the Court on 16 April [T. 6740]. A reduced copy of the schematic plans will be provided to the Coroner.

6.3 A copy of the schematic plans will be kept in each unit, centrally at the administration building and copies will be provided to the MFB and the local police station. The schematic plans include unit floor plans, a whole of site plan, specific plans showing such things as assembly points for the whole of site, location of

gas mains, water for the MFB, electric shut-off points and where dangerous or flammable substances are stored.

6.4 All training centres and community based accommodation will now be required to produce floor plans which comply with the MFB standards. These floor plans will be required to be kept in both the house/unit and in an alternative location to provide a backup system if required.

7. EVACUATION PACKS

7.1 Evacuation packs have now been produced and placed at the fire panel in each unit [T. 6742]. The evacuation packs were initiated from consultation with the MFB. The MFB provided advice on the contents of the pack and suggestions regarding where the pack should be stored.

7.2 KRS purchased backpacks, for ease of carrying, to store important items. The evacuation packs are consistent in appearance and content (save for incentives) across all units.

7.3 The evacuation packs consolidate all the information previously available in each unit into one handy pack. The pack contains such things as a warden's hat and jacket, client lists, torch and some packs contain lollies, drinks and the like as incentives for clients.

7.4 Standards have been developed for maintaining the evacuation pack including a daily check on the location and contents and that the torch batteries are charged. This check must be signed off by the Unit Manager's delegate daily.

7.5 Consultation with the MFB is continuing to ensure the evacuation packs are utilised appropriately within the evacuation procedures at KRS. Recent consultation with the MFB has resulted in the purchase of flashing lights for use by wardens to mark assembly areas and the fire warden's location. The portable lights are now contained in the evacuation packs.

7.6 All Disability Services' training centres and CRUs will be issued with evacuation packs with clear instructions to ensure that critical emergency information and items such as warden's hat and jacket and client lists are included. These packs will be required to be stored in a central point within the unit/house. The information must be easily accessible and transportable in an emergency. The evacuation packs utilised at KRS will be used as a best practice model for all other Disability Services' institutions and houses

8. FIRE SAFETY COMMITTEE

8.1 In July 1996 the KRS Fire Safety Committee was re-convened and has met bi-monthly since that time [T. 6747]. The Committee has broad representation from both direct care and non-direct care areas. It comprises:

- the Manager, KRS;
- all three Sector Managers;
- Unit Managers and Deputy Unit Managers (who often are the designated fire wardens in each unit);
- the Ancillary Services Manager, KRS;
- the Maintenance Manager, KRS;
- the AHCOT team leader.

8.2 The Manager, Redevelopment, provides executive support to the Committee.

8.3 The Committee identifies key issues and provides feedback on safety initiatives. The Committee also ensures fire safety has an ongoing high profile. Its terms of reference are:

- to oversee the implementation of the new fire safety system and identify issues and solutions;
- to identify staff training requirements and best responses;
- to monitor emergency responses, identify issues and solutions;
- to prioritise and recommend relevant equipment purchases;
- to provide ongoing feedback on the fire manual and propose amendments as required;
- to collect and analyse data relevant to fire safety improvements;
- to discuss and propose standards for endorsement by the Manager, KRS.

8.4 A key task of the Committee is the quarterly analysis of the evaluation of fire drills. It has already addressed a number of operational issues such as the evacuation packs, staff/visitor lists in units, buddy orientation and training needs.

8.5 All Disability Services training centres will be required to establish a Fire Safety Committee which comprises both direct care and non direct care staff of the centre. Each Committee will undertake a quarterly analysis of fire drills and identify key safety issues and responses for the centre. The Manager, Client Services will establish an appropriate structure for Community Residential Services programs to ensure fire safety issues are highlighted and responded to as a priority issue.

9. KRS/MFB LIAISON

9.1 Since April 1996 there has been ongoing consultation with the MFB concerning important aspects of fire safety at KRS. Such aspects include the fire manual, fire evacuation procedures, the evacuation pack and client lists. KRS also arranged for Wormald Fire Systems to conduct training sessions on the new fire safety system for the MFB.

9.2 This consultation has been formalised by the establishment of a KRS/MFB Liaison Committee, an initiative of the Manager, KRS [T. 6749]. The first meeting was held Thursday, 23 January 1997, and there has been a subsequent meeting.

9.3 It is intended that the Liaison Committee meet three times per annum. Its terms of reference are:

- to contribute to fire safety, prevention and awareness at KRS;
- to identify any fire emergency response issues and solutions;
- to identify any fire drill issues and solutions;
- to identify any fire safety improvements;
- to share information on new initiatives including redevelopments at KRS.

9.4 The first meeting was considered to be very productive with both KRS and the MFB providing positive feedback. Some of the outcomes of the first meeting are as follows:

- protocols are to be developed in respect of AIU isolation;
- AIU isolation procedures have been developed for switchboard;
- pathways defined for feedback/issues from MFB to KRS;
- notification to local MFB stations of AIU isolation;
- Wormald training of MFB in the new fire safety system;
- feedback given on training, including updating and targeting appropriate people;
- MFB to observe drills;
- MFB to have group orientations at KRS;
- relocation of KRS locality map to a more appropriate location;
- improvement of unit signs to include unit number and address;
- a feature map of KRS to be organised in the Melways ensuring street names highlighted;
- installed blue road tracking;
- MFB provided with general information including addresses of community-based houses.

9.5 As stated above, an initiative arising out of the first meeting was the MFB orientation to KRS [T. 6744]. In April and May 1997 six orientation visits occurred involving 48 fire officers attending 9 units.

9.6 Information and matters discussed at the Liaison Committee are passed on to the Fire Safety Committee by means of the Manager, KRS. The Manager, KRS chairs both meetings and is responsible for ensuring that the two committees are aware of issues being considered by the other committee as appropriate and, if necessary, for the joint consideration of matters.

9.7 All training centres will set up a similar liaison structure with the local MFB or CFA which will facilitate orientation visits, formal feedback on evacuation drills and improvements which can be made in existing systems. The Manager, Client Services will establish an appropriate structure for Community Residential Services programs to ensure such liaison occurs.

10. DRILLS

10.1 Prior to April 1996, drills had been conducted at KRS on a regular basis but subject to the following deficiencies:

- there was no established schedule of the number and times of drills;
- the records of the drills were inadequate;
- the drills were not comprehensive and did not cover all contingencies;
- reliance upon false alarms to provide a range of practice was inadequate in the face of structured and evaluated fire drills.

10.2 It is now a requirement, set out in the KRS fire manual, that units must complete six drills per annum, including at least two night drills [T. 6743]. The responsibility for drawing up a schedule of daytime drills lies with each Unit Manager, together with the relevant Sector Manager. The schedule of night drills for each unit is prepared by AHCOT. The night drills must include one drill during the evening period and one whilst the clients are in bed.

10.3 Each drill is evaluated by a Unit Manager from another unit, using the Fire Drill and False Alarm Evaluation Form (Appendix B). The Fire Drill and False Alarm Evaluation Form has been revised and attached to it now is a follow-up Action Sheet. The MFB were consulted about the form to improve both the training experience and the opportunity to gather and analyse drill information. This enables full information to be provided on what improvements in drill procedure are required. The previous form did not allow sufficient space for a description of the drill's merits or shortcomings.

10.4 Following an evacuation drill or false alarm, the completed Evaluation Form is provided to the Manager, KRS, the appropriate Sector Manager and to the relevant Unit Manager. A copy is also placed on the fire safety file at central administration. The follow-up Action Sheet from the evaluation is addressed by the Sector Manager. The Unit Manager of the unit that performed the drill is expected to address those issues which are identified in the follow-up Action Sheet as requiring action within the unit and to provide feedback to the unit staff.

10.5 Further, the drill evaluations are analysed quarterly by the Manager, KRS and the Fire Safety Committee. Trends and issues arising from the analysis are discussed at the Committee meetings. Any issues which require action arising from the meeting are then addressed through line management.

10.6 By way of example, the analysis which has occurred since the new system was implemented suggests that there is:

- an increased understanding of the evacuation process by staff;
- greater clarity of duties for staff during evacuations;
- improved staff skills in the use of evacuation tools, such as wheelchairs and evacuation blankets;
- increased focus by staff on fire evacuation safety issues, such as the location of lists in flat, exits and the like;
- improved staff skills in highlighting potential evacuation hazards in units;
- improved staff skills in the use of firefighting equipment.

10.7 The analysis of the Evaluation Forms also identified that the evacuation packs were not kept in the most convenient position in the unit. After consultation with the MFB, it was determined that the evacuation packs be kept by the fire panel in each unit.

10.8 The analysis of the evaluation forms also identified that fire wardens needed to be more assertive during the evacuation. To address this a strategy has been developed in conjunction with the MFB that includes warden training. Information sessions have also commenced to discuss particular issues to improve evacuation procedure, the first of which focussed upon the assertiveness of fire wardens.

10.9 All loops in the fire safety system have conducted orientation visits for buddies both day and night, so buddies are familiar with the units that they will be assisting in the evacuation of. Buddy orientation is scheduled to occur quarterly, and includes a verbal briefing by each Unit Manager on unit-specific issues [T. 6744].

10.10 There were 114 planned drills conducted on site between April 1996 and April 1997. In addition to this, a further 16 false alarms resulted in evaluated evacuations. The average evacuation time during the day is 4.5 minutes and, at night, 5.7 minutes [T. 6743].

10.11 The MFB has provided expert advice on evacuations including evacuation of units with residents with physical disabilities [T. 6744]. The MFB has also been requested to observe seven day and night drills over the next nine months [T. 6744]. The first observations commenced on 14 May 1997. Feedback and assessment from these observations is provided to unit staff at the time of the evacuation and more formally to the MFB/KRS Liaison Committee.

10.12 The MFB has stated that its involvement will be aimed at increasing the learning opportunity rather than testing the evacuation times. This will be achieved by adding levels of complexity to the drill scenario. For example, by including an injured fire warden in the evacuation or utilising smoke. The learning opportunity will also be expanded through the post-drill debriefing by the MFB.

10.13 The drills to be observed by the MFB will target a cross-section of building types and client groups. In addition to this, units experiencing difficulty with drills will also be involved further to maximise the learning opportunity.

10.14 To ensure an appropriate level of training and monitoring of fire drills and false alarms all training centres will be required to undertake six fire drills per unit per annum. CRUs will be required to undertake 4 drills per annum. The number of drills which are observed by the local MFB/CFA will be determined at a local level between management and the MFB/CFA. All drills will be required to be evaluated and a follow up sheet produced detailing action required for improvements. The systems established at KRS for scheduling, evaluation and follow up drills will be utilised as a best practice model for all other Disability Services' institutions and houses. All institutions and houses will also be required to record all evacuations due to false alarms and to complete Departmental incident reports for all false alarms.

11. FIRE SAFETY & RESPONSE TRAINING

11.1 To address the inadequate coverage of staff in fire safety and response training, a comprehensive training program was launched in April 1996. The objective is to provide to all staff at KRS fire safety and response training.

11.2 Fire safety and response training is conducted by the MFB and covers many areas including:

- fire prevention and awareness;
- use of fire fighting equipment;
- co-ordinating staff in an evacuation to maximise safety;
- planning for emergencies;
- hazard and risk analysis.

11.3 Between April 1996 and April 1997, 26 fire safety and response training sessions were conducted and 438 staff were trained [T. 6744]. The training program is ongoing.

11.4 A system of refresher training for all staff is being developed by KRS, including ways of practising the "methods of rescue" component of the training. This will include increasing the complexity of drills and also discussing the fire warden's role and evacuation scenarios at unit meetings.

11.5 The next level of training is the advanced fire safety training [T.6744-45]. It provides more detail on the role of the fire warden, hazards and fire prevention. In June 1996 the Unit Managers, Sector Managers and the After Hours Co-ordination Team participated in the advanced fire safety training.

11.6 In March and April 1997 sessions in fire warden training were conducted [T. 6745]. This training was initiated as a result from feedback on the drill evaluation forms. A total of 73 staff have now undertaken the fire warden training.

11.7 The MFB has suggested that fire warden seminars will improve the staff's understanding of the fire warden role. In response, KRS has organised seminars to be conducted on site later this year and will target fire wardens for an open and frank discussion of the issues they may face in carrying out their tasks.

11.8 Orientation/induction training for all new staff at KRS has a component on fire safety and evacuation. This component is being expanded by the Fire Safety Committee to include the role of the fire warden. The object being to improve the response of staff to the instructions given by the fire warden during an evacuation.

11.9 At the request of KRS, Wormald Fire Systems has conducted training on the new fire safety system, including the use of the fire panel [T. 6745]. As at June 1997 sixteen sessions have been held providing training to 106 staff members. Regular fire panel training will continue to be scheduled. As part of the management audit role of AHCOT, unit staff will be asked questions relating to their knowledge of the fire panel during the audits to be carried out by AHCOT.

11.10 On the recommendation of the MFB, KRS will conduct training sessions for senior staff later this year in how to conduct fire safety checks [T. 6745]. The training will include information on specific acts and regulations pertinent to fire safety, real and potential hazards, rectification process and a site inspection.

11.11 On a statewide basis Fire Safety and Response training is mandatory for all direct care staff and managers in Training Centres. In the community based sector all house supervisors and cluster and sector managers across the State will be undertaking Fire Safety & Emergency Procedures training from August to November. The training will alert these staff to the need to develop fire safety awareness and responses for their own services. All other direct care staff in the community based sector will be required to undertake the self-paced learning package developed in conjunction with the MFB referred to in section 4A of this document. Fire Warden training will be mandatory for all Unit Managers, Deputy Unit Managers and After Hours teams in all Disability Services Training Centres. This training will include information on the role of the warden during emergencies and non emergency responsibilities. A policy with respect to requirements for refresher training is being developed.

12. CLIENT LISTS

12.1 Prior to April 1996 the client lists were located in each unit and centrally at the administration building. The client lists were not however uniform in placement and the central list was in alphabetical order rather than units.

12.2 Further, the previous fire manual at KRS referred to a roll call as one of the necessary elements of the emergency procedures. Unfortunately, the old fire manual did not suggest making a client list accessible to the MFB in the event of a fire.

12.3 In recognition of these deficiencies, all client lists were reviewed and it was determined that:

- a master list of each unit would be kept in the evacuation pack;
- a whereabouts list would be kept at the exit to each unit during the day;
- a whereabouts list would be kept in the evacuation pack at night;
- a master list would be kept centrally at the administration building at all times. [T. 6746]

12.4 During the day the master list for each unit is to be kept at the exit to each unit. The master list is a complete list of all clients residing in the unit.

12.5 A whereabouts list is also kept at the exit indicating which clients are not present in the unit for what periods during the day. A staff/visitor list is also stored at the entrance during the day indicating whether there are any visitors to the unit, or whether staff are absent from the unit.

12.6 At night, any client or staff movement is recorded on the handover sheet which staff are required to complete at handover. This is stored with the master list in the evacuation pack and a copy is also kept at the central administration building with AHCOT.

12.7 This system ensures that at all times there is an up to date list of the people present in the unit and which is located at the unit. A centrally located back-up list is also available.

12.8 As an additional safeguard, master lists with photos of residents in each unit have been arranged. They will be placed in the client files, at central administration and in the evacuation packs. The lists will be updated annually.

12.9 KRS has engaged in extensive liaison and consultation with the MFB in respect of the purpose, format and locations of the master lists, whereabouts lists and client information cards.

12.10 Disability Services will require that all training centres and CRUs maintain up to date client master lists and "whereabouts" or movement lists. The list should include a client identification card which contains a client photograph and details. The list must be accessible and able to be removed in an evacuation. A second backup list will be required to be kept at another appropriate location. The client identification material should be checked annually and updated as required. The client lists and associated procedures developed at KRS will be used as a best practice manual for all other Disability Services' institutions and houses.

13. FIRE SAFETY MANUAL

13.1 The current yellow KRS fire safety manual was produced in June 1996 to coincide with the introduction of the new fire safety system. A copy of the manual was distributed to the parties at the Inquest on 6 November 1996 and is exhibit 66.

13.2 It had been anticipated, prior to the fire, that the red fire manual would be replaced with a new fire manual commencing with the launch of the new fire safety system. The new fire safety manual was developed in close consultation with the MFB including ongoing review during drafting [T. 6747]. The MFB have recommended and KRS will ensure that a review of the fire safety manual occurs at a minimum of every six months.

13.3 As a result of a review of the fire safety manual, it has recently been updated to include a standard evacuation procedure. Priority amendments relating to procedural or general information (under the direction of the MFB) may occur more frequently than the minimum six months.

13.4 Unit Managers are required to ensure that all staff are familiar with the fire safety manual. All staff must sign a form indicating that they have read the manual. If staff are having difficulty understanding any part of the manual, the Unit Manager must delegate a Deputy Unit Manager to assist the staff member through the learning process.

13.5 The process of reviewing the fire safety manual commences with feedback to the Fire Safety Committee from staff and management as well as feedback to KRS from the MFB. Once issues are identified and addressed by way of draft amendments to the manual or changes in procedure they are referred to the MFB Fire Prevention Unit for consideration. It is only after approval by the MFB that the amendments are endorsed by the Fire Safety Committee.

13.6 Each unit is required to return its copy of the fire safety manual to KRS administration where the updated material is added to the manual and returned to each unit. Prior to receiving the updated manual, staff must read the amendments and sign off that they understand the procedures in full.

13.7 In May 1997 the Fire Safety Committee introduced a companion folder to the fire safety manual to ensure the strictly procedural nature of the manual and to hold all working documents relating to fire response and procedural checks. The fire administration folder (distinguished by being in a white folder) holds all the checklists for the system and sign off sheets showing when staff have most recently read the fire safety manual.

13.8 The companion folder includes chapters on the fire safety system, checks, evacuation procedures, regular checks including sprinkler gauges and detectors. The manual was "policy of the month" for June 1996. The standard fire orders are displayed in key locations in all units.

13.9 A standard fire safety manual, based on the KRS manual, will be developed for all training centres and community based accommodation in consultation with the MFB. Locality specific information will also be included in the manuals.

13.10 Evacuation procedures for training centres and community residential units have been developed to replace those currently contained in the IDS Accommodation Services Emergencies Manual. The revised procedures for community residential units are consistent with the procedures contained in the Fire Safety and Emergency Procedures Training Manual and have been endorsed by the MFB. These procedures are currently with the Minister for endorsement prior to printing. The new procedures are consistent with standard fire orders. Previously the manual contained an instruction that staff should fight a fire where it was safe to do so. On the advice of the MFB this has been amended. The new Manual also incorporates into evacuation procedures the requirement that the evacuation pack be maintained and used when there is an evacuation.

14. KRS POLICY AND PROCEDURE MANUAL

14.1 Following a review of the previous KRS Policy and Procedure Manual, the current KRS Policy and Procedure Manual ("KPP manual") was released in June 1996 [T. 6760-61]. The KPP manual provides KRS specific procedures where appropriate. All relevant policies and procedures for direct care staff are therefore contained in the following documents:

- KPP manual;
- Accommodation Services Practice Instructions;
- Accommodation Services Emergency Manual;
- KRS Fire Safety Manual;
- KRS Unit Supervision Policy.

14.2 The KPP manual includes an index guide which provides easy reference to all policies based on a key word system. The references provided with each topic refer to the relevant policies noted in the previous paragraph. All staff have received a personal copy of this index guide and new staff are provided with a copy at orientation.

14.3 During staff induction training the manuals and the index system are introduced to staff for their procedures and reference value. At unit orientation new staff are referred to most frequently accessed procedures and mandatory reading, such as the Fire Safety Manual. The Unit Manager provides orientation or delegates the task to the Deputy Unit Manager. The KPP manual includes standard minimum content for unit orientation.

14.4 The KPP manual is to be reviewed on a six monthly basis when all KRS specific policies and procedures are considered by the KRS executive for appropriate context and relevance. Staff contribute to the review through a working group (auspiced by the executive) and via line management.

14.5 Updates to the manual are performed in the same manner as that for the KRS Fire Safety Manual.

14.6 Each month a "policy of the month" is highlighted [T. 6761]. This policy is determined by the Manager, KRS, based on topical or relevant issues. Staff are required to present key issues at unit meetings that relate to the policy of the month and the Unit Manager must nominate staff to make a presentation within a unit context scenario. Staff must also sign off that they have read and understood the policy concerned.

14.7 Disability Services will require all regions which do not have a similar manual in place to produce such a manual specific to the needs of the region which addresses matters not addressed in the Accommodation Services Practice Instructions and the Accommodation Services Emergency Manual.

15. ROAD TRACKING AND SIGNAGE

15.1 At the KRS/MFB Liaison Committee, the MFB recommended the introduction of reflective road tracking to identify from the roads and lanes the location of water hydrants. This has now been implemented by KRS [T. 6749].

15.2 Other improvements include making the unit signs light-reflective and to indicate both unit number and address [T. 6749-50].

15.3 The relocation of the directional map at the entry to the site will be completed shortly.

15.4 Where appropriate road tracking will be introduced at all training centres.

16. MINOR CAPITAL WORKS

16.1 KRS has an annual cycle of minor works and maintenance. A number of minor works initiatives have been undertaken or are planned to improve safety.

16.2 These include the following [T. 6750]:

- improved external lighting covering routes to assembly areas;
- improved external lighting of assembly areas;
- ramps at Unit 28/29;
- outward swinging exit doors on all unit exit doors;
- a single master key system;
- electrical improvements including earth leakage and fire system cabling to be upgraded;
- improved unit signs;
- reflective dots to denote beds with evacuation blankets in all units;
- the replacement of fibron with villaboard in all units (being 12 in total) which had fibron, which is now complete;
- portable flashing lights/beacons at assembly points [T. 6742];

- establishment of a central "locker" with key emergency information which will include a back-up client master list, floor plans, master keys and the like.

17. FALSE ALARMS

17.1 The number of false alarms at KRS in the period May to November 1996 was 26 percent less than that for the same period previously. The improved performance was highlighted in a letter from the MFB to KRS [T. 6755].

17.2 The reduction in false alarms is the result of:

- the demolition of a number of obsolete buildings, thereby reducing opportunities for false alarms; and
- increased staff awareness and vigilance in the use of appliances.

17.3 The false alarms and the incidence thereof have been discussed at the KRS/MFB Liaison Committee. The monitoring of false alarms will be an ongoing agenda item at the KRS/MFB Liaison Committee meetings.

18. UNIT MEETINGS

18.1 All units hold staff meetings every roster, being once per month. Unit meetings have been reviewed and performance criteria noted as follows [T. 6756-57]:

- agenda items for all meetings must include - date, staff present, policy of the month presentation, IPP presentation by key worker, management report, fire safety, unit business;
- meetings are to be held both shifts every roster;
- minutes to include "action arising" and "responsible person";
- minutes to be approved by the Unit Manager or Deputy Unit Manager who attended the meeting;
- minutes must be comprehensive enough so staff not at the meeting can understand the issues discussed when they read the minutes;
- staff not present at the meeting must sign off that they have read the minutes;
- meetings must include mandatory discussion of fire safety, client IPPs, policy of the month and management memos and documents.

18.2 The minutes of the unit meetings will be regularly checked as part of the KRS management audit process.

18.3 The KRS format will be adopted as best practice at all training centres.

19. MANAGEMENT QUALITY SYSTEMS

19.1 A number of quality assurance measures have been implemented at KRS, including a peer review and management review [T. 6757-58]. The object of the quality assurance measures is to ensure that the improvements in respect of fire safety that have been implemented are carried out, and are carried out effectively.

19.2 The existing quality assurance checklist has been supplemented by two new checklists, being:

- a management quality audit including general fire safety issues (for example, clear exits, location ofequipment, etc) as well as broader issues of KRS procedures awareness, IPPs, file work, clean offices and egress points, unit meeting minutes;
- night services checklist which was developed by the Fire Safety Committee. It includes handover, firesafety issues (for example, clear exits, location of fire keys, night lighting etc), client safety, alertness of staff, interaction with clients, safe use of electrical appliances and unit specific issues.

19.3 The management quality audit will be conducted by the three Sector Managers and the Manager, KRS on one unit every two months. The Sector Managers will complete the questionnaire. The questionnaire covers the office administration, fire safety issues, client file maintenance and staff supervision. The Manager, KRS, will also question staff on various issues. The information is then compiled and given to the relevant Sector Manager to action with the appropriate Unit Manager.

19.4 The night services checklist is conducted by AHCOT staff on every unit every month [T. 6765]. The checklist covers unit specific issues, handover, drug supplies and fire safety issues. It is being expanded to include night staff familiarity with the fire panel. The information is provided to the Sector Manager for processing in the same manner as the management quality audit. A quarterly review of all issues is compiled with a checklist of outcomes. Any fire safety issues are directed to the Fire Safety Committee.

19.5 Both checklists cover a range of areas and include specific references to fire safety issues and systems.

19.6 The MFB will also be training senior KRS staff to undertake fire safety hazard identification audits in the second half of 1997.

19.7 The Disability Services Branch will develop an implementation plan and consultative process to facilitate the Quality Services Framework across all training centres and community residential services.

20. MANAGEMENT OF NON-DIRECT CARE

20.1 Prior to March 1997 the non-direct care area at KRS and the direct care area at KRS were managed separately. That is, the direct care area reported to the Manager, KRS and non-direct care services reported to the Manager of Support Services.

20.2 As from 1 March 1997 the management of all non-direct care services at KRS transferred to the Manager, KRS [T. 6748]. This will result in a closer relationship between direct care and non-direct care and will centralise the responsibility for local fire safety with the Manager, KRS.

20.3 Portfolio responsibility for all facets of fire safety has been assigned to the Manager of KRS, including the development of the safety plan for the site.

20.4 All regions will be required to put in place a structure which ensures local co-ordination of fire safety issues.

21. HANDOVER

21.1 Until April 1997 handover times between shifts varied from between 6 to 12 minutes. The handover requirements were outlined in the previous Departmental Instruction "Active Night Duty, Sleepover and Handover" (DI-1994-11). KRS also required that staff complete a day and a night report.

21.2 A review of the day/night report format and handover at KRS was conducted in February 1997. As a result of the review a new handover format has been introduced including references to fire safety (Appendix C). Further, the handover time has been extended to fifteen minutes at the beginning and the end of each shift for all units. This ensures that all relevant critical information is appropriately disseminated and alerts staff to the importance of these issues.

21.3 The previous Departmental Instruction has been reviewed and replaced by the Disability Services Practice Instruction, "Client Monitoring During Active Night Duty, Sleepover and Handover". The New Practice Instruction was developed following consultation with all Departmental Regions and was released in May 1997 after it was piloted in three Departmental Regions. The Practice Instruction states that at the commencement of their shift incoming staff must check all clients and read recent entries in the communication book or the relevant shift for further information on night routines and individual client needs. The format of the handover sheet used at KRS and associated procedures developed at KRS will be used as a best practice model for all other Disability Services' institutions and houses.

22. GSP/IPP STAFF AWARENESS AND MANAGEMENT ROLE

22.1 The improvements in this area have been outlined in the statement made to the Inquest (exhibit 267). The statement has been set out in the "Acknowledgments" section of these submissions.

22.2 Further improvements have been put into place to ensure the relevance and appropriateness of GSPs and IPPs [T. 6763-64]. In particular, the IPP which should become the "working document" for the day to day management and development of the clients.

22.3 These initiatives include:

- the Assessment of Needs and GSP training for Unit Managers and Deputy Unit Managers;
- a complete revision of the key worker system, with an emphasis on staff roles and responsibilities in relation to IPPs;
- discussion of an individual client's IPP at the monthly unit meeting;
- quality control mechanisms including a "bring up" system to ensure GSPs are completed on time and random audits of client files. The file audit includes checks on the current GSP and IPP, as well as the appropriate location of other reports.

22.4 In mid 1996 the key worker system was reviewed to establish the best practice in relation to staff supervision and equity of workload. This directly impacts on improving staff skills and accountability around roles and

responsibilities. The review of the key worker system has provided accountability measures around the IPP that require key workers to submit monthly progress reports to Unit Managers for discussion and evaluation during supervision. A supervision checklist includes other IPP accountability measures as does a formal monthly progress plan.

23. RECORD KEEPING

23.1 The improvement in the standard of record keeping was outlined in the statement made to the Inquest (exhibit 267). The statement has been set out in the "Acknowledgments" section of these submissions.

23.2 The improvements included the introduction of the Accommodation Services filing system and the new computerised Client Information System.

23.3 Until more recently, record entry and record keeping has been based on a hard copy system and the outdated Client Information System ("CIS"). This, coupled with an historical and at times ad hoc approach to file entries has resulted in records not being satisfactorily comprehensive or comprehensible.

23.4 The Accommodation Services File provides a clear and prescriptive approach to the recording and storage of information [T. 6762]. It ensures that all relevant information in relation to an individual is contained in one location and that GSPs and IPPs are more readily accessible.

23.5 The new Disability Services Client Information System ("DISCIS") is currently being implemented in stages. DISCIS is a more user-friendly recording and information system and includes case notes, program information and the capability to identify current behaviour as an "alert" and make behaviours which are no longer current "inactive".

24. CLIENT ALERTS

24.1 Whilst client "alerts" have been in existence for many years, the client information system was not user-friendly nor amenable to updates. The new Disability Services Client Information System has provided the opportunity to improve the client alert system. Client alerts can now be reassessed and updated regularly and the system has the capacity to make an alert "inactive" as appropriate [T. 6759].

24.2 In addition, the Eastern Metropolitan Region and KRS are developing a local process to support the placement and review of client alerts including key steps and any consultation required [T. 6760]. Both "firelighting" and "fire risk" can be registered as an alert.

25. INCIDENT REPORTS

25.1 On 18 December 1996 the Manager, Client & Family Support, forwarded a memo to all Managers, Client Services, Disability Client Services and Disability Accommodation Services, advising that: "... where any client is involved in any incident related to firelighting behaviour an incident report should be completed. This includes any client who shows an interest in fire materials."

25.2 A copy of the memo is annexed to the statement of Pam White ("PW 8") (exhibit 258.64).

APPENDIX 3.3 '*A PRESCRIPTION FOR PREVENTION*' – THE METROPOLITAN FIRE BRIGADES BOARD (DEPARTMENT OF JUSTICE) RECOMMENDATIONS

LEARNING FROM THE TRAGIC EXPERIENCE

SMOKE ALARMS, EARLY MFB RESPONSE AND AUTOMATIC SPRINKLERS

47. The signal lesson of the tragic experience of the fire at KRS is that a local smoke alarm system, early MFB response times and automatic sprinklers save lives.

48. A smoke alarm giving early, local and audible warning allows a fire to be contained and persons in danger to be rescued, the MFB to be called and, if possible, the fire to be extinguished at an early stage. Such a system must therefore be installed in all residential care facilities.

49. The Australian standards must be observed in the installation of the system. False alarming must not be allowed to undermine the system, as occurred at KRS, but should be investigated and prevented.

50. Even the upgraded alarm system at KRS is not yet fully local and there are deficiencies in staff knowledge of and training for the operation of that system. These matters should be addressed urgently.

    Recommendation No 1: A system of smoke alarms must be installed in all residential care facilities. In the case of a class 3 and class 9a building the system must comply with AS 1670-1993 and in the case of a class 1 building the system must comply with AS 3786-1993. These recommendations are to be made retrospective with works being completed within an acceptable time frame, 5 years. Note 1: This may require the replacement of thermal detectors with smoke detectors/alarms. Note 2: The standard of alarm system required will be dependent on the coverage provided by a sprinkler system.

    Recommendation No 2: Where false alarming is occurring in a smoke detector system, systematic appropriate remedial action must be taken, and smoke detectors must not be inappropriately changed for thermal detectors as a solution.

    Recommendation No 3: The current problems with the alarm system at KRS must be resolved as a matter of urgency. The system must be made fully addressable and identify room numbers, rather than zones; at the very least the system should be programmed to perform at the best of its capabilities. Maps showing the room numbers should be installed next to the mimic panels and the main alarm panel. Rooms should be marked with room numbers so as to familiarise staff with those numbers. The AHCOT team must receive notification on their pager of the location of the unit in alarm.

    Recommendation No 4: The Department of Human Services must ensure that all relevant staff at KRS have a full and operational knowledge of the addressable mimic panels at units and the main panel at the administration centre.

51. The MFB has a performance target of achieving a response to alarm of fire within 7.7 minutes in 90 per cent of cases. The MFB bettered that target in the present case by arriving at KRS within about 5 minutes 37 seconds. That early arrival was fundamental to the fire attack and evacuation, including the saving of two lives. If the alarm had been earlier, the MFB would have assisted in saving the lives of all of the deceased and prevented any loss of life to clients or staff in the dangerous circumstances presented in the initial stages of the fire and evacuation.

    Recommendation No 5: The Metropolitan Fire Brigade should continue with its aim to reduce response times to alarms of fire. The Brigade should be commended on the 1996/97 goal of achieving response times of 7.7 minutes in 90% of cases. It should be acknowledged that the Brigade's prompt response to the fire at Unit 30/31 saved lives.

52. The evidence in the inquest established that automatic sprinklers are life safety devices. Had an automatic sprinkler system been in operation at the time of the fire in Flat E then the fire would have been extinguished prior to any lives being lost (but see below as to partial sprinklering). Any danger to clients, KRS staff and MFB fire fighters in the early stages would have been minimised. This accords with the accepted industry position and successive findings of State Coroners and Deputy State Coroners in previous inquests. Automatic sprinkler systems must therefore be mandatory in residential care facilities.

53. KRS now has a system of partial sprinklering. Areas not sprinklered are not separated by proper fire walls from areas that are. Partal sprinklering is inadequate and places the clients and staff of KRS at significant risk. The situation at Unit 7/8 is particularly serious. This matter must be addressed urgently.

Recommendation No 6: Residential institutions must have a sprinkler system that complies with the minimum requirements of AS2118.4 of 1995 installed in all compartments including roof spaces where fire separation is not provided for. Sprinklers must be installed at all residential care properties, regardless of their classification. This is particularly important following the move to integrate the mentally disabled into the community and move them directly into class 1b occupancies. It should be noted that buildings in this classification can still retain security mechanisms such as bars on windows, locked doors and polycarbonate glazed windows. These recommendations are to be made retrospective with works being completed within an acceptable time frame of 5 years. Fire separation of compartments excluded from sprinklers should only occur in accordance with section 2 : 10 AS 2118.4 of 1995.

Recommendation No 9: The system of sprinklers to be installed in residential care facilities should be a complete - not partial - automatic sprinkler system. Where there is not complete sprinklering then there must be fire separation at compartments excluded from sprinklers in accordance with AS 2118.4 1995, Clause 2.10.

Recommendation No 10: All units at KRS where there is partial sprinklering must be upgraded to full sprinklering as soon as possible with Unit 7/8 receiving immediate priority.

54. The residents of Flat E were locked in a “death trap”. In such premises automatic door unlatching devices should be installed to provide escape in case of fire. This requirement may be reassessed where there is a full local smoke alarm system and comprehensive sprinklering.

Recommendation No 7: If clients must be housed in locked premises then the doors must be fitted with automatic unlatching devices to provide ease of escape in a fire emergency.

Recommendation No 8: If it is necessary for residential care facilities to be provided on a secure basis then it is critical that automatic sprinklers and a local alarm system be provided in such premises.

TRAINING, EVACUATION AND EMERGENCY PROCEDURES, CLIENT/STAFF RATIOS AND MANAGEMENT OF CLIENT RISK BEHAVIOUR

55. The staff at KRS are dedicated but the evidence revealed that the procedures relating to such matters as training, record keeping, emergency response, client management and staff/client ratios were inadequate.

56. The inadequacies are described in detail in the submission. Examples include:

- Fire evacuation drills and training was not undertaken by all relevant staff and did not include all areas of risk.
- Fire safety manuals and documents existed but they needed revision and many staff had no knowledge of them and were not required to read them.
- Record keeping by unit management and direct care staff was poor and few staff had adequate knowledge of client files.
- Induction and transfer procedures were inadequate and did not result in incoming direct care and management staff having sufficient knowledge of emergency response procedures or risk behaviours in units.

57. Many of these deficiencies were in the course of correction in the period running up to the time of the fire. The Department of Human Services made statements in the inquest acknowledging some of the deficiencies and setting out the manner in which they were being, or would be, addressed.

58. A central concern of the MFB is that emergency and fire safety procedures for residential care facilities are best developed and implemented through a consultative approach. The evidence in the inquest revealed that fire safety systems in such premises raise issues that are multi-faceted and inter-related. No one agency has sufficient expertise to address all of the issues in the necessary comprehensive way. Recommendations regarding these and related areas are made.

Recommendation No 11: The Department of Human Services should set up a consultative task-force to review emergency and fire safety procedures at all Department residences and facilities.

Recommendation No 12: The generic emergency procedures must be reviewed and amended for each institution. The MFB should be represented on the taskforce to design generic emergency and fire safety procedures for Department residences.

59. Adequate staff training is critical so that any emergency response is timely and effective. Improvements to the staff training regime at KRS will bring about a greater capacity to prevent fires and evacuate clients in the event of a fire occurring.

Recommendation No 13: All staff must receive training in the emergency and fire safety procedures relative to their level in their institution or facility.

Recommendation No 14: The Chief Fire Safety Warden at each residence or facility must maintain a training log.

Recommendation No 15: All new staff or staff that are new to an institution or facility must undertake the training as a compulsory part of their induction program.

Recommendation No 16: Every unit at Kew Residential Services must have a short booklet provided to all staff and available for all temporary staff to inform them of the basic procedures for that unit.

Recommendation No 17: The Department of Human Services must ensure that all staff with low English language proficiency have adequate access to emergency procedures.

Recommendation No 18: The Department of Human Services must ensure that appropriate training time is allocated to fire safety training.

60. The existence of an evacuation plan for KRS has been acknowledged, and the deficiencies identified, including differences in the "buddy system".

Recommendation No 19: The "buddy system" mechanism at Kew Residential Services must be changed as a matter of urgency so that the nearest units respond to an alarm.

Recommendation No 20: As part of the continuing upgrade of the fire safety system at KRS every unit at Kew Residential Services must have a primary and secondary evacuation point, marked by a beacon.

61. The concept of an Emergency Information Locker as developed by the MFB would be especially useful at KRS and similar residential care facilities. Such a locker would contain information, plans, client lists, fire keys and the like which would be readily accessible in an emergency situation and overcome some of the problems encountered by the MFB and KRS staff on the night of the fire.

Recommendation No 21: Each unit at Kew Residential Services must have an Emergency Information Locker. The MFB should assist the Department of Human Services in designing and manufacturing Emergency Information Lockers for Kew Residential Services and similar institutions.

Recommendation No 22: All doors at Kew Residential Services and similar institutions should be keyed with a single key.

62. Two staff per unit to care for 46 disabled clients at night is insufficient having regard to the degree of fire risk at residential care facilities. The determination of staff/client ratios at such facilities does not take adequate notice of fire safety considerations. This concerns the safety of both the clients and the staff. Proper attention to this issue at KRS and similar facilities is vital.

Recommendation No 23: The Department of Human Services must set up a task force to approach the issue of appropriate staff-client ratios and to report within twelve months.

Recommendation No 24: Any changes in the staff or client make-up of a unit at Kew Residential Service must be advised to the Chief Fire Safety Warden for the consideration of the fire safety implications of such a change.

63. The deficiencies in the management of Paul' fire lighting behaviour or fire risk behaviour have been identified. Reforms already introduced will remedy many of these deficiencies but some issues remain outstanding.

Recommendation No 25: The categorisation of the behaviour of a client in a particular category should not be allowed to obscure the true nature and degree of the fire risk presented by that behaviour.

Recommendation No 26: All staff at Kew Residential Services must be trained in risk management, to a level commensurate with their responsibilities. An approved risk management model such as FEMA should be used.

Recommendation No 27: All Department of Human Services direct care staff should be made aware of the MFB/CFA Juvenile Fire Awareness and Intervention Programme. They should be encouraged to refer suspected or actual firelighters or those with fire risk behaviour.

Recommendation No 28: A simple system of noting client alerts must be used so that staff can access this information easily. Alerts should not be graded but simply notify the staff member of a risk, rather than the

frequency or severity of the behaviour. The current move at Kew Residential Services to access all client alerts on unit computers should continue.

64. Paul set alight the fire which killed the nine men with a cigarette lighter of a kind freely available for retail purchase. This highlights the need to introduce appropriate legislation to ensure that only cigarette lighters which have standardised child resistant features are available for purchase. Paul may well not have been able to use a lighter having these features and the tragedy could have been prevented.

Recommendation No 29: The introduction of legislation to prohibit the sale of cigarette lighters not having child resistant features should be supported and a standard should be developed setting out the required characteristics of such lighters. In the interim, child resistant lighters of the kind manufactured by Bic should be made available for sale at residential care facilities.

MAINTENANCE

65. The automatic fire detection and alarm system that was in place at KRS at the time of the fire was intended to be one to which AS1670 applied. The maintenance requirements for such a system are set out in AS1851. The evidence established that it is fundamental to the proper operation of such a system that these standards be fully complied with.

66. Jonkar Industries was responsible for the maintenance of the system at KRS and was expressly required to comply with AS1670 and AS1851 in so doing. Indeed the annual detector checking requirements were in excess of AS1851.

67. The evidence established that Jonkar Industries did not maintain the system in accordance with the standards. The deficiencies were substantial and resulted in the system being compromised. Some defeciencies were not actually caused by the company but it did not act to correct them as it was bound to do. The deficiencies included:

Incorrect placing of detectors, and failing to relocate detectors, too close to objects on ceilings, walls, fluorescent light casings, exhaust fan openings, etc.

- Over-painting of detectors.
- Dented or otherwise damaged detectors.
- Failing to check and report on the implications of building alterations.
- Failing to maintain a proper logbook and other records.
- Failing to bring instances of non-compliance to the attention of KRS management.

Jonkar Industries also failed to keep proper records and plans. The evidence established that after the fire a false plan was manufactured by the principal of Jonkar Industries.

68. As stated above, KRS should have been aware of the deficiencies in the performance of Jonkar Industries but was not. Local KRS staff thought that its performance was being monitored by the Building Services Agency ("the BSA") but in fact this was not so. This raises an issue of fundamental importance for the supervision of maintenance contracts across the public sector generally. Urgent attention is needed to ensure that the maintenance problems which occurred at KRS do not occur again at that institution, at similar institutions or at other institutions such as hospitals and schools.

Recommendation No 30: The Government, and in particular the Department of Human Services, must develop a procedure for the regular monitoring and auditing of fire maintenance contractors. The MFB and the BSA should be involved in this process.

Recommendation No 31: All alarm systems at Department residences must be maintained in accordance with AS1851.8.

Recommendation No 32: All fire maintenance contractors who perform work at Department of Human Services Properties must be required by contract to detail in writing any proposed changes to the detection system.

Recommendation No 33: The Department of Human Services must consider a means of intervention to identify damaged detectors and protect detectors from repeated damage.

Recommendation No 34: Any maintenance at Kew Residential Services must be approved by the Chief Fire Safety Warden by way of a permit system.

Recommendation No 35: The Department of Human Services must ensure that a full fire audit is carried out at all residential care facilities within the next twelve months and audited annually thereafter.

Recommendation No 36: The MFB should be considered as a suitable long term auditor of Department fire systems in various institutions and facilities.

BUILDING ISSUES, RENOVATIONS, INTERIM MEASURES AND ISSUES AFFECTING THE FIRE PROTECTION INDUSTRY

69. The building in which the fire occurred (Unit 30/31) was renovated several times in the years prior to the fire. Due consideration was not given to the fire safety implications of the renovations, and the unsafe situation for clients was continued and in some case worsened as a result. Opportunities for improvement of the safety of the system were sadly missed.

70. The deficiencies in the consideration and implementation of the renovations resulted in part from inadequacies in the building regulations regarding premises used for the provision of residential care accommodation and regarding the renovation of such premises.

71. There has been disagreement between the expert witnesses in the inquest as to whether Unit 30/31 should be classified as a Class 3 or Class 9a building under the Building Code of Australia ("the BCA"). Probably the building falls to be classified under Class 3. But the real problem identified in the inquest is the pressing need for the reform of the BCA so that the fire safety requirements of residential care facilities are properly prescribed. This should be done through a consultative approach, and must include a requirement for sprinklering. These requirements must be incapable of waiver and apply to Government buildings as well as private buildings.

Recommendation No 37: The Building Code of Australia must be reviewed to include buildings that house the intellectually disabled, but are not hospitals. A consultative approach involving experts in the care of the intellectually disabled, fire prevention experts and risk managers must design appropriate standards for fire protection for such buildings.

Recommendation No 38: That the following regulation be adopted:

Accommodation for the aged, disabled or children

(1) This regulation applies to any building which is a common place of long term or transient living for a number of unrelated persons who are aged, disabled or children.

(2) A residential type sprinkler system complying with AS 2118.4-1994, or other equivalent fire suppression system, must be installed in the building.

(3) Where the sprinkler system referred to in sub-regulation (2) has more than 100 heads or the building referred to in sub- regulation (1) is registered to accommodate more than 32 residents, the system must be connected to fire brigade in accordance with Building Control Commission Practice No. 7.

(4) This regulation must be complied with:

(a) within 5 years of the date of commencement of this regulation; or

(b) at change of tenancy or management of the entire building; or

(c) at the change of ownership of the entire building- whichever is earlier.

Recommendation No 39: Regulation 5.7 of the Building Regulations (1994) must be amended such that it is no longer applicable to buildings housing the aged, intellectually disabled or children.

Recommendation No 40: That all government instrumentalities and public authorities be bound by the technical, administrative and any future amendments of the Building Act and the Building Regulations.

72. The evidence in the inquest showed that, despite the efforts of KRS staff, the fire protection industry did not deliver interim protective measures to KRS. As already stated, relatively inexpensive local audible alarm options were available. These were rejected by ULA/SSL on inadequate grounds and without proper consideration. There were deficiencies, also, in aspects of the approach of KRS staff to this issue.

73. As a result of the inquest there must be a reconsideration by the industry of the significance of interim measures. Existing stumbling blocks such as resistance to novel approaches and lack of fast track standard setting procedures must be overcome.

Recommendation No 41: The Fire Protection Industry must change their philosophy in relation to interim systems.Whilst acknowledging that it is the responsibility of fire engineers to develop appropriate interim systems, it seems that there is a consensus view among fire engineers that the interim systems must comply to standards or be elaborate in nature. This is not the point - interim systems are there to provide short term corrective measures for otherwise deficient systems and may comprise of simple measures. They are not meant to bring systems up to standard - a full fire upgrade may be necessary for that. A discussion paper on the role of interim or corrective measures should be developed (the Fire Services should have input into the development of such a document) so as to spark industry discussion as to the development of the interim measures philosophy.

74. The concept of a "full fire audit" generated confusion amongst certain parties in the inquest. This should be appropriately addressed to prevent such confusion from occurring the future.

Recommendation No 42: The State of Victoria, together with the fire protection industry and the MFB, must produce a policy document outlining the requirements of various types of fire audits and fire reports expected from consultants engaged by Government departments and public authorities.

75. Australian Standard 1851.8 makes provision for the testing of smoke detectors but not for the testing of the sensitivity of such detectors. As the evidence in the inquest showed, protection of life is afforded not simply by the operation of a detector but by its timely and efficient operation.

Recommendation No 43: Australian Standard AS 1851.8 must be extended to include the testing of the sensitivity of detectors. The MFB should be consulted in relation to these changes.

76. A substantial number of detectors at KRS were impact damaged. This can result in the compromise of the detector and lead to loss of life in a fire. AS1601.1 97 and AS1601.2 87 do not include provision for the protection of detectors against damage and the public is generally not aware of the dangers of such damage. This matter requires appropriate attention.

Recommendation No 44: Australian Standard 1603.1 of 1997 and AS1603.2 of 1987 must be amended to include appropriate mechanisms for preventing impact damage to detectors, such as the compulsory use of sensor guards in risky locations. Such sensor guards must be of the type that do not interfere with the sensitivity of the detectors. Purchasers must receive information and warnings about the risks that impact damage may have on detectors and the necessity of implementing regular testing and preventative mechanisms.

MANAGEMENT ISSUES FOR THE DEPARTMENT OF HUMAN SERVICES

77. The inquest has raised a wide range of significant issues relating to both human resource and material resource management. Existing systems for the management of these issues within the Department of Human Services should be upgraded. Only by this means can these issues, and the continuing challenges and opportunities in the area of fire safety generally, be appropriately responded to. This applies to KRS (while recognising the gains made in this area to date), the wider Department of Human Services and other Government departments.

78. A proper fire safety management system would have a number of essential features:

- Within the Department of Human Services - a State Fire Safety Officer.
- Within each residence or facility - a Fire Safety Committee chaired by a Chief Fire Safety Warden.
- Proper training of these personnel and support by senior management within the Department of Human Services and the relevant facility.

79. These initiatives should form part of a process for the reform of the approach of Government to fire safety in residential care and like institutions, a process which should include consideration of proper building design.

Recommendation No 45: The Department of Human Services must appoint a State Fire Safety Officer.

Recommendation No 46: Every Department residence or facility must appoint fire wardens for appropriate areas and a Chief Fire Safety Warden for the entire residence or facility. The Chief Fire Safety Warden shall serve on the local Fire Safety Committee.

Recommendation No 47: The Department of Human Services must set up a task-force to design a programme to educate Chief Fire Safety Wardens as to their responsibilities. All Chief Fire Safety Wardens must receive this training before commencing in this position.

Recommendation No 48: The Department of Human Services must appoint a Fire Safety Committee at every Department residence or facility, which should include Class 1b occupancies. An appropriate Fire

Service Officer should serve on that committee. The Committee must be appointed and meet at least once in the next six months. The Fire Safety Committee will be charged with the responsibility of amending the generic emergency procedures (see above) for their institution and shall assist the State Fire Safety Officer in disseminating fire safety information. Once the emergency procedures have been drawn up, the Committee must meet at least once every six months. They must produce a report every six months to be distributed to the State Fire Safety Officer and the appropriate fire service.

Recommendation No 49: The Department of Human Services must appoint a committee to look at the appropriate design of buildings for Department residential buildings. This should be a consultative approach with appropriate experts in issues such as fire prevention and risk management. A report must be produced within twelve months outlining detail of appropriate life safety levels.

APPENDIX 3.4 BSA'S VISION – A SYSTEMS APPROACH – THE BUILDING SERVICES AGENCY (DEPARTMENT OF INFRASTRUCTURE) RECOMMENDATIONS

E. PROPOSALS FOR MANAGEMENT OF ESSENTIAL SERVICES SYSTEMS

E.1 BSA'S VISION

Since its formation, BSA has been working with clients to improve asset management practices. BSA has assisted a number of clients to undertake reviews of their premises as required by the Minister for Finance guidelines including review of the essential services of the buildings. Particularly since the fire at Kew Cottages, BSA has given detailed consideration to strategies to ensure proper maintenance of essential services. Through a number of workshops with some of its most experienced managers, BSA has developed some ideas which are realistic and capable of implementation (see section E.3 and following). In addition, a blueprint for maintenance management in the ideal environment has been developed. Although some clients may consider this idealistic model to be beyond their means, it nevertheless serves to demonstrate, from a consultant's perspective, how maintenance could be managed.

BSA has a vision for optimum property and services maintenance management. BSA believes that this vision is an appropriate starting point for consideration of future improvements.

In an ideal environment, every government Department would review every building under its responsibility in order to:

- assess to what extent the buildings and services comply with Building Regulations and other safety requirements (see section E.3 below)
- identify works required to bring the building to a level of safety and fitness to occupy (including both one-off works and on-going maintenance)
- establish and review records relating to essential services maintenance
- establish and review the procedures which assist staff in ensuring proper maintenance and proper safety systems for building occupants contractors and consultants.

In an ideal environment, every building would have a detailed "maintenance plan" including a program addressing compliance with the BCA and other regulations and legislation. The maintenance plan would take into account all other aspects of the building fabric, services and finishes.

The maintenance plan would be periodically reviewed, for example, every five years or less for residential buildings and others with specialist use and each time some significant event occurs such as a renovation. This would ensure that the maintenance plan remains appropriate to building use and also to verify implementation. Changes of building use and requirements of occupants would be picked up in the routine reviews of the maintenance plan.

If maintenance plans were required, building design would consider safety in the building and the ongoing life cycle maintenance issues. The building surveyor should be responsible to ensure that safety and future maintenance issues are considered at the time of issuing the building permit ie before any construction commences. When

works are complete, it should be a pre-requisite to issue of the occupancy permit that a maintenance plan be in place ie before the building was suitable for occupation.

The maintenance plan should be subject to the certification of a registered building practitioner. For example, there should be provision for registration under the Building Act 1993 of a new category of "building practitioner" specialising in built asset management. Such practitioners could develop, certify and/or review maintenance plans.

Although BSA's vision for a planned and systematic approach to maintenance includes a number of far-reaching proposals, BSA believes the idea has considerable merit particularly in the climate of out-sourcing of expertise, down-sizing of organisations and devolution of responsibility to the operational level within government agencies. A similar approach would be equally applicable in the private sector.

E.2 GOVERNMENT POLICIES

The Victorian government has recently introduced a number of policy initiatives which are cumulatively beginning to have a significant impact, improving building standards.

E.2.1 Building Act 1993 and Guidelines. This Act introduced a number of reforms in mid 1994 including registration and insurance of building practitioners, privatisation of the building permit process and, for the first time in building control legislation, binding the Crown by some provisions. The Act gives power to the Minister for Finance to issue guidelines to promote better building standards for buildings owned by the Crown. Guidelines issued in November 1994 require existing publicly owned buildings to be brought to a standard that is safe and fit to occupy and Departments are required to report annually to Parliament on their progress in implementing the guidelines. The Guidelines were intended to bring the public sector into line with private sector building control as a transition to becoming fully bound by building control legislation.

E.2.2 Asset Management. The Victorian government, as part of continuous improvement, developed the "Asset Management Series" designed to assist agencies manage assets, particularly land and buildings. Various guidelines have now been produced to further assist agencies. Office of Building and Development, Department of Infrastructure provides information and assistance to agencies on asset management issues.

E.2.3 Building (Further Amendment) Act 1997. The Building Act 1993 has recently been amended to bind the Crown. From 1 August 1997, government buildings will be subject to all the provisions of the Building Act 1993 and the Regulations.

E.2.4 VMIA. The Victorian Managed Insurance Authority has recently been established by statute to provide insurance and risk management services and advice to government. Risk management strategies are encouraged in each Department as part of VMIA's risk management role. Health and safety and protection of people and property are priorities.

E.2.5 BCC. The Building Control Commission has recently released an "Emergency Services Maintenance Manual" to assist building owners and their consultants addressing the important obligations for maintenance of essential services required by Part XI of the Building Regulations 1994.

E.3 ESSENTIAL SERVICES SYSTEMS

The inquest has dealt with fire protection which is one part of health, safety and amenity in buildings generally. Many of the recommendations and proposals in this submission are of equal application to other aspects of health and safety. In Part XI of the Building Regulations 1994, the term "essential services" includes fire safety, exit pathways, airconditioning and related matters and in this submission the term has a meaning consistent with the Regulations although the term does have a much wider use generally,

Consideration could be given to mandatory reporting of safety defects in buildings or related systems. A program in the Victorian WorkCover Authority Health & Safety Division akin to the health and safety improvement, prohibition and proposed infringement notices could be considered or alternatively a program within the BCC through its expert building inspectors or alternatively again a program through local council building surveyors who have already some obligations under the Building Act 1993 in relation to dangerous building works.

Recognising that the maintenance plan ideal may be some time away and building on the recent government reforms, BSA has identified a number of initiatives which may be implemented, by it and other organisations, both separately and in co-ordination, to promote better building standards in the area of essential services implementation and maintenance. These matters are set out in the following sections.

E.4 PHYSICAL REVIEW OF PREMISES

E.4.1 Compulsory audit of premises within specified time-frame. Some Departments currently undertake audits to record and review the condition of buildings and/or compliance with regulations. BSA undertakes such

audits for a number of clients who are then in a position to develop programs for maintenance and upgrade works based on the audits.

E.4.2 So that outcomes are consistent, audits should use a common format which will make the task easier and enable best of the result.

E.4.3 Strategic mandatory ongoing inspections (spot checks). BSA offers to clients the service of systematically auditing buildings but to take this a step further, such audits could be compulsory and ongoing so that implementation of audit findings is also reviewed and the condition/compliance issues are re-visited.

E.4.4 Building permit for new fire protection systems and other essential services. This is currently required but the process could be enhanced by incorporating requirements for future maintenance.

E.4.5 Certificate of compliance with relevant Australian Standard called up in the BCA for existing fire protection systems within a specified time-frame. This would involve expert appraisal of existing systems within, for example, a period of two years, to identify works required to ensure compliance with the relevant Australian Standards.

E.4.6 BSA would support regulatory changes needed to implement the above recommendations.

E.4.7 Existing bodies and approval systems could be utilised for these purposes, for example, BCC and BPB.

As part of BSA's term maintenance product, it will offer clients a report on their essential services for the purpose of the client complying with Part XI of the Building Regulations 1994. BSA also offers clients advice as to how to close the gap between what exists in the building and what is required by law.

E.5 HARDWARE REQUIREMENTS

E.5.1 BSA supports proposed regulations (expected to take effect from 1 August 1997) requiring supported residential care buildings to be fitted with sprinklers within five years. It would further assist if amendments were made to the Building Regulations or BCA clarify precisely which class of buildings are required to comply with the particular fire safety requirements. For example, there is confusion about whether certain residential care buildings should be classified as class 1b, class 3 or class 9 buildings.

E.5.2 BSA recommend extending the requirement for sprinklers to ensure that all residential care buildings are covered. See paragraph E.5.1 also.

E.5.3 Hardware systems should appropriately balance the needs of warning and control of fire.

E.5.4 The building approval system should be used to support and enforce these initiatives so the building surveyor has a role in ensuring compliance.

E.5.5 The Australian Building Codes Board (ABCB) or the BCC may be well placed to review and if appropriate adopt Australian Standards or other appropriate codes or standards for determining requirements

E.6 RISK ANALYSIS AND MANAGEMENT STRATEGIES

E.6.1 Recognise the need for comprehensive risk analysis and the development of appropriate strategies to control risk. VMIA is a legislative initiative for risk management which could include these matters and extend to building safety and risk management pre-construction, for ongoing maintenance and upon any change of use of the building.

E.6.2 Consideration has been given to the NSW Government policy of government funded projects to implement risk management plans. However it should not be only monetary value of works that determine when risk management is required but also safety consequences of the project e.g. fire protection works should always be subject to a risk management plan irrespective of their value. The Victorian government has chosen the VMIA approach instead but the NSW system will provide interesting comparison.

E.6.3 Develop personnel management strategies for prevention, warning, response (including evacuation) and control of fire, to be integrated with and supplement hardware systems

E.6.4 Interim risk management measures should be determined and put in place while permanent hardware and personnel management requirements and strategies are developed and implemented

E.6.5 Building, systems and use changes should be implemented pursuant to and consistent with a determined strategy, rather than in an ad hoc manner

E.6.6 Risk analyses should be first undertaken to ensure safety of occupants in relation to all proposed building works, including renovations and refurbishment, to ensure fire protection is not compromised by those

works taking into account the works, the change of use etc. The building permit and occupancy permit should be used as tools to reinforce this by referring to the risk analysis.

E.6.7 There is also reference to "alternative solutions" under the proposed Regulations - see clause 1.8 and 2.1(7) on pages 5 and 6 of the draft of the proposed Building (Further Amendment) Regulation 1997.

E.6.8 BSA recommends the integration of risk management concepts and processes in maintenance of fire protection systems, and ensuring education of those who undertake such maintenance in risk management principles and techniques, including ongoing review of the system.

E.6.9 Adapt BSA's Occupational Health and Safety System (or a similar system) for major projects so it can be generally adopted for minor works and maintenance contracts where the system can be seen to produce safety benefits both in the undertaking of the works and ensuring quality of the works. BSA seeks to assist its clients in meeting their obligations under section 22 of the Occupational Health and Safety Act 1985.

E.6.10 A program of awareness and education about legal obligations and compliance methods could assist interested stakeholders involved in the provision and maintenance of fire protection systems (including owners, agents, staff, contractors and consultants).

E.6.11 Recommend use of risk management principles relating to awareness and compliance as a key criterion in the selection of consultants and contractors

E.6.12 BSA recommends that any changes in use must be taken into account during the annual inspection of essential services required under Part XI of the Building Regulations

E.7 CONTRACT SPECIFICATIONS

E.7.1 ABCB may be the most appropriate body to review all available standards and codes to determine specifications for design installation and maintenance of fire protection systems which will be most likely to ensure ongoing integrity and effective operation of such systems.

E.7.2 BSA recommend the inclusion in contract specifications of:

- requirements for compliance with the measures and outcomes determined in accordance with paragraph E.7.1 above.
- requirements for the contractor to provide evidence of and the contract administrator to audit the use of effective management systems designed to achieve and verify specified outcomes.

This will encourage a healthier contracting environment.

E.7.3 As an alternative, ensure specifications make sufficient provision for auditing the works (which is currently not an industry standard practice) and enforcement of compliance.

E.7.4 Ensure clarity and consistency of specifications, particularly in the areas of delineation of respective authorities and responsibilities, communication, record- keeping, supervision, systems and performance auditing, and risk analysis and management. Where appropriate, standard specifications could be developed for use across a range of Departments and agencies as is happening in a number of other areas at present.

E.8 QUALIFICATION OR LICENSING

E.8.1 BSA recommends the implementation of a system of qualification or licensing of consultants and contractors involved in the design, installation and maintenance of fire protection and other health or safety systems, by reference to criteria including technical, managerial and financial capabilities.

E.8.2 Training and certification of relevant personnel should be a requirement for qualification or licensing of consultants and contractors.

E.8.3 The existing registration responsibilities and functions of the Building Practitioners Board (BPB) under the Building Act 1993 could be extended to consultants and contractors involved in the design and works relating to fire protection, and other health or safety related systems.

E.8.4 The BPB and agencies could utilise and rationalise existing and proposed databases of fire protection or other health or safety practitioners maintained by various organisations and agencies and Departments such as Office of Building & Development, Department of Human Services and the Institution of Engineers.

E.8.5 As proposed in E.8.1 above use awareness and compliance with risk management principles as a key criterion in the qualification, licensing and selection of fire protection practitioners.

E.9 CONTRACT ADMINISTRATION AND COMMUNICATION

E.9.1 Terms of engagement, task identification and delineation of respective roles, authorities and responsibilities should be agreed and clearly recorded in formal documentation between the owner and all agents, consultants and contractors.

E.9.2 As proposed in E.7.4 above, contract specifications should make clear provision for and delineation of authorities and responsibilities for the proper administration of fire protection systems works and maintenance contracts.

E.9.3 By means of both contract specification and implementation of practical strategies, there should be measures in place for formal and informal communication between all parties to fire protection works, including the owner, agents, consultants, contractors and the Metropolitan Fire Brigades Board.

E.9.4 The contract specification and practical strategies, should be used to ensure the recording of all communications and reports (formal or informal) and mechanisms for follow up action or responses

E.9.5 Term Maintenance guidelines and supporting software data management systems have been developed by BSA which may be used or adapted for fire protection systems maintenance to ensure all parties are aware of the contractual obligations of the parties, processes and outcomes required by the contract and methods of fulfilment

E.9.6 The owner, as Principal to a fire protection systems works or maintenance contract, should ensure the identification of the precise extent and outcomes of the proposed works, to ensure that there are not any misunderstandings which may result in no-one undertaking what may be key components such as auditing or performance review

E.10 INFORMATION SYSTEMS FOR RETENTION AND ANALYSIS

E.10.1 Various recommendations have been made above for the gathering and retention of information, and they are emphasised as being critical to the proper assessment and management of fire risks

E.10.2 It is necessary to have current, extensive and accurate information about the nature extent location and condition of componentry of fire protection systems and this means that it is critical to have systems for the gathering analysis and retention of information which is then readily accessible.

E.10.3 BSA has developed proprietary software for the computer-aided gathering, analysis, retention and generation of information in relation to building services. This software may be adapted for valuable use in relation to essential services systems

APPENDIX 3.5 UMOW LAI & ASSOCIATES PTY LTD RECOMMENDATIONS

5.0 RECOMMENDATIONS

5.2 We submit that the inquiry should make recommendations as follows:

GOVERNMENT BUILDINGS

1. Clause 19 of the Building (Further Amendment) Bill 1997 which extends the operation of the building permit, occupancy permit and building inspection system to Government controlled buildings be strongly endorsed.

2. Clause 19 be proclaimed to commence immediately.

3. A training, education, information and cultural change program should be instituted as soon as possible to widely inform and advise facilities and building managers and Government officers generally that private sector standards now mandatorily apply to all Government buildings.

4. All Government buildings should be subjected compulsorily to a fire safety audit within a specified time frame. In this regard, the efforts of the Office of Building are strongly supported.

5. A program of mandatory ongoing inspections of Government buildings by qualified and experienced fire engineers and surveyors should be instituted.

6. The highest priority and urgency should be given by Treasury to the implementation of fire safety upgrade recommendations arising from fire safety audits.

7. A systematic program should be instituted to upgrade all Government buildings so that they comply with the Building Code of Australia.

8. A streamlined approval and funding process should be adopted to fast track 'Immediate' or 'Urgent' projects desirably by Ministerial initiative to ensure the prompt and effective fire safety upgrade of Government buildings.

9. Senior management should be held accountable and must take responsibility for the preparation and implementation of facilities master plans and for the fire safety condition and fire safety upgrade priority given to Government buildings.

10. The Office of Building (or Departments and authorities as appropriate) should be required to raise and maintain a computerised fire safety compliance register listing in relation to all Government buildings relevant building details, including classification, salient history, fire safety audit details, and outstanding non-compliances, requirements and works.

11. All necessary regulatory changes should be implemented to achieve the above recommendations.

BUILDING PERMITS APPLICATIONS AND PROCEDURES

1. Training should be conducted as to the implications for Government building managers as to the implications for them of the Building (Further Amendment) Bill 1997. In particular, in seeking building permits for Government buildings, it will now be necessary (as with private building work) to make application for building permits in the prescribed form; to provide building practitioners in writing with all prescribed or necessary information and to be responsive to their requests for information including for example:

    - class of building
    - past use of building
    - proposed use of building
    - number of persons likely to occupy building
    - extent of works proposed
    - fire safety measures proposed
    - a plan clearly showing the layout dimensions of any existing building and the extent of proposed works
    - details of all building works over the past 3 years.

2. Occupancy permits will now become mandatory as will the conduct of inspections.

3. It should be made mandatory for building practitioners when considering building permit applications to:

    - inspect the file held by the relevant local municipality relating to any existing building as to which approval is sought;
    - ensure that details of all applications and approvals are provided to the relevant municipality for its building files;
    - physically inspect any existing building as to which application is made;
    - personally inspect all buildings for which approval has been granted or confirm that another qualified building practitioner has completed interim and final inspections.

MAINTENANCE

1. An accreditation scheme for Government building fire system maintenance contractors should be introduced.

2. Government building fire system maintenance contracts should be awarded only to accredited maintenance contractors

3. Maintenance contractors will remain accredited only if they operate a quality assurance system with proper record keeping and work procedures.

4. Accredited maintenance contractors are required at all times to adhere to Australian standard AS 1850, and will be subjected to periodic quality audits by the accreditation authority.

FIRE AUDIT STANDARD OR GUIDELINES

1. In the absence of any Australian Standard or code of practice governing the scope and methodology of the various types of fire audits, the Fire Code Reform Centre (or Standards Australia) be requested to develop an Australian Standard or code of practice for the conduct of the various types of fire audits.

2. The Metropolitan Fire Brigade or the national organisation of which the MFB is a member be represented and provide input to the Fire Code Reform Centre in the development of an Australian standard or code of practice for the conduct of fire audits.

5.3 Should it be of assistance to the inquiry to do so, we will expand on the conclusions or recommendations set out above.

Note: Since writing the above, we have been instructed that the Building (Further Amendment) Bill 1997 has become the Building (Further Amendment) Act 1997 (Act no 34 of 1997). The operative parts of the Act are yet to be proclaimed but must come into operation no later than 1 July 1998.

APPENDIX 3.6 WORMALD FIRE SYSTEMS RECOMMENDATIONS

4 RECOMMENDATIONS FOR CHANGES TO THE FIRE DETECTION AND PROTECTION SYSTEM INSTALLED AT KRS ON BEHALF OF WORMALD

4.1 The practice of two contractors working on the same fire detection and protection system (by way of alteration, or service and maintenance) is prone to confusion and highly irregular in the fire protection industry. Wormald strongly recommends that it should cease.

4.2 If recommendation 4.1 is rejected and the system of using two contractors is to continue, there should be a system whereby the work done by each contractor is fully documented and provided to the other contractor immediately and there should be monthly meetings between KRS and the two contractors to exchange information about the operation and updating of the system.

4.3 The programming of the loop system at KRS should be altered from the present system which is dependent on the loop on which the building is located. Buildings contiguous to the building where the alarm has gone off should register that alarm on their mimic panels and by the activation of their lights and hooters.

4.4 The mimic panels in the buildings at KRS are not capable of identifying the detector that has gone into alarm. They presently identify a zone number which can then be located by reference to a map (eg zone 2021 might be Flat B in Building 37). The programming on the mimic panels should be altered so that the display shows the Flat number rather than the zone number.

4.5 To allow identification of the particular detector that has gone into alarm from every building, it would be necessary to replace the mimic panels with FIPs in each building and to program them into the system. If this were done, all the FIPs (ie the main FIP and all the building FIPs) would have text identifying the room in alarm. This would be an improvement on the existing information on the main FIP which can only show the number of the detector in alarm. To identify the room in alarm currently requires reference to the map folder at the main FIP. The cost of this would be substantial. The FIPs cost $3000 per unit plus the cost of installation and programming.

4.6 All staff at KRS who may have to use the main FIP should be fully trained in its operation and there should be regular refresher courses to ensure this proficiency is maintained. In particular, staff at the administration building must be fully conversant with the procedure for identifying the detector and room which is in alarm. The staff member pushes the alarm acknowledgment button once to acknowledge the alarm. He or she then pushes the “point” button a second time to show the number of the detector in alarm and then identifies the room location by reference to the map at the main FIP. This information should be given to staff in the building in alarm to speed evacuation from the affected area and to the MFB while in transit to allow it to proceed directly to the room in alarm.

4.7 At present, the only place from which it is possible to identify the detector and room in alarm is from the main Fire Indicator Panel. It would be possible to have a pager system with the present equipment which would allow the zone in alarm to be identified (and if the zones were re-programmed to show flats, the Flat in alarm). If the mimic panels were replaced by FIPs, the pager would then also be able to identify the detector in alarm. Until some such solution is in place, there should always be a staff member on duty at the

main administration building who can obtain information about the detector in alarm immediately from the main FIP. This is particularly relevant to the after hours situation where only two members of staff are at the administration building.

4.8 The possibility of pagers which would allow night staff to identify the Flat in alarm or the detector and room in alarm from locations away from the main FIP - as outlined in 4.6 - should be investigated.

4.9 Automatic door release mechanisms should be installed. These could be activated by the alarm system or, if this was prone to abuse, by a secure manual release point on the outside of the building in alarm.

4.10 The buildings should be fully sprinklered. This would avoid the danger of fire developing in the unsprinklered area of a building to a point where it cut off fire escape doors and/or overwhelmed the sprinklers in the sprinklered areas.

APPENDIX 3.7 VILLAMANTA LEGAL SERVICE RECOMMENDATIONS

The Coroner's investigation is based on the jurisdiction in the Coroners Act 1985 to investigate deaths of persons held in care (section 17(1)) and the jurisdiction to investigate fires (section 31). The majority of the evidence in the inquest dealt with fire safety and fire systems.VLS considers these matters of importance. However we submit the Your Worship should give precedence to matters related to the administration of the Intellectually Disabled Persons' Services Act 1986 . We urge Your Worship to direct specific attention in your recommendations to this issue.

HISTORICAL CONTEXT.

The following is not based on evidence presented in the course of the inquiry. It is based on our experience and work with people who have an intellectual disability. It is provided to Your Worship in the hope that it provides further insight into competing factors, both past and present, which influence those who live at Kew Residential Services. It is also hoped it will be of assistance in developing recommendations which will affect the future lives of people who have an intellectual disability and who need supported accommodation services.

The notion that the State should be responsible for the care of people who have an intellectual disability dates back to the early nineteenth century. State operated institutions for people who had a mental impairment were based on hospital models. There was little or no distinction in the provision of services to people who had an intellectual disability as opposed to those who had a mental illness. Institutions were staffed by doctors and nurses, people slept and lived in wards. They offered asylum for those seen as vulnerable or dangerous in the community at large. In Victoria, this model remained relatively unchanged until the 1960's. At that time advances in drug therapy for people who had a mental illness created an incentive to distinguish models of service delivery for people with a mental impairment. The need for a 'medical model' for delivering services to people with an intellectual disability began to be challenged. At the same time Government policy began to embrace deinstitutionalisation. Other factors that led to deinstitutionalisation were:

- the acceptance of concepts of normalisation, which tried to make patterns and conditions of everyday life close to those found in mainstream society
- the emergence of human rights issues which stressed the need for the least restrictive environment as a guide to community-based care.

These changes can be demonstrated in the legislative framework for delivering services to people with a mental impairment. Prior to 1986 services for both people who had a mental illness and people who had an intellectual disability were regulated by the Mental Health Act 1958. Residential institutions for people who had either disability were often co-located and jointly administered. For example Willsmere administered services for people who had a mental illness as well as those who had an intellectual disability who lived in Kew Cottages.

In 1986, reflecting trends overseas, the Victorian Government delivered a legislative reform package repealing the 1958 Act and replacing it with the Intellectually Disabled Person's Services Act 1986 the Mental Health Act 1986 and the Guardianship and Administration Board Act 1986 . This legislation attempts to provide a framework which bridges changes from institutional based, paternalistic, medical models of care where a single state operated service is responsible for "whole of life" service to community based, rights focussed services where individuals have access to a range of specialist and mainstream service providers.

People who live at Kew, including those who died in the fire, are caught between the "old" and "new" service delivery systems. Consistent with the legislative framework since 1986 and future planning, the number of residents at Kew is declining. The average age of residents is increasing. Younger people who have an intellectual disability and are unable to live with their families are not admitted to residential institutions. They live in community based accommodation, with support tailored as much as possible to their individual needs.

Inconsistent with the legislation, the quality of services such as KRS have declined as funds have been "bled" to pay for the new services. Rather than allocate additional or "bridging" resources to support people in community based supported accommodation, governments have ignored provisions such as section 5 of the Act, and have tended to extract funds from institutions through reduction in staff numbers and closure of institutional beds to pay for new services.

At the same time the legislative framework in place since 1986 has influenced KRS and "like" institutions to attempt to enter the spirit of the "new "service delivery system with limited funds. This is evidenced by the make-shift renovations to Unit 30/31.

Many of the current residents at KRS have lived at there since childhood. It is the only home they know. Based on our experience and work with people who have an intellectual disability, it is our understanding, some will want to live there until they die. Many, if given the opportunity, will embrace the opportunity to live in community based accommodation with appropriate support. For most of these people "challenging behaviour" exhibited in an institutional setting will disappear in alternative accommodation settings.

VLS 's suggested recommendations for consideration by Your Worship should be seen in this historical context. The existing legislative framework outlines a model for current and future residential services for people who have an intellectual disability. This model is an anathema to the model in existence at KRS both now and at the time of the fire. The current system of service delivery at KRS is somewhere between the ``old'' system, which relied on segregation of people who had a disability, institutionalisation, paternalism and protectionism, and the ``new'' system, which emphasises integration, normalisation, individual rights and services which are responsive to the needs of individuals.

Recommendations made by Your Worship should, in our submission, address the need for those who will remain at KRS to be free from unacceptable risk to their safety but also be applicable to models of community based supported accommodation which are consistent with the Principles of the *Intellectually Disabled Persons' Services Act* 1986 and the effective administration of the legislation.

FIRE SAFETY SYSTEM AT KEW

Fire safety depends on the person responsible to respond to the fire being aware of the location of the fire and taking appropriate action. The action may be suppression of the fire or evacuation. This is as true in the suburban home as of an institution the size of Kew.

Locating the fire in a place the size of Kew is much more difficult that in a small home. This was apparent on the night of the fire. The new system at Kew features addressable detectors. On alarm the detector signals to the fire indicator panel that it is in alarm. If a person is at the fire indicator panel they have merely to push a button and the number of the detector in alarm appears. On looking at a map kept at the panel the room in which the detector is in alarm can be identified.

At the same time a local mimic panel in the unit identifies in which zone the detector has gone into alarm. This panel is unable to advise which particular detector is operative and thus the room can not be determined at the local level. For the unit to discover which detector has gone into alarm and in which room, a call must be made to the administration building or the administration calls the unit.

VLS suggests Your Worship recommend

That until a technical solution is found the Department should ensure that the fire indicator panel is constantly monitored by a staff member.

VLS submits that the current system is technically flawed in that the discovery at the local level of where the detector has operated relies on information being received from administration. Since the installation of the new system there is not a staff person monitoring the fire indicator panel all the time. If, at night, the AHCOT members are busy in another part of Kew, they would have to return to the administration building to press the button to disclose which detector is in alarm. Villamanta understands that Wormalds are attempting to resolve this problem through the use of pagers somehow connected to the fire indicator panel. If this can be done the AHCOT members will be able to phone

the unit and advise the detector in alarm and then the unit will have to look that up on a map to work out in which room the detector operated.

VLS suggests Your Worship recommend
That all staff receive regular instruction and familiarisation with the fire detection system. In the induction of new staff there must be training and familiarisation.

VLS notes that there has been some reluctance by staff to learn the new system. It must be impressed upon staff that they are integral to fire safety, not just the fire hardware system.

Once a fire is located it may be possible to suppress it. Some responsibility for this has been taken over by the introduction of sprinklers. However sprinklers are generally restricted to bedrooms.

VLS suggests Your Worship recommend:
That staff be made aware of the limitations of the fire sprinkler system and that the sprinkling of the double storey unit be extended to cover the entire premises.

VLS is concerned that there is insufficient sprinkling at Kew. In the double storey unit the sprinkling is limited to the upstairs. VLS notes that the sprinkler system is a domestic type system. It can operate only a limited number of heads before water pressure is dramatically reduced.

VLS notes that the Department is investigating this.

Kew has introduced a new client file management system called DISCIS. recommends that staff be trained in suppression of fire. VLS notes that the Department is ensuring that this is being done in a systematic manner.

It may be that on locating the fire staff have to evacuate the unit. The formalisation of the buddy system has been achieved. Your Worship has raised the problems resulting from the geographical restrictions of the current loops. The Department has assured Your Worship that this matter is being investigated to develop a technical response. Until that is achieved some of the buddy units have to be alerted by telephone.

VLS suggests Your Worship recommend that:
The Coroner be kept informed about the technical developments despite the ending of the inquest.

If the technical difficulties are insuperable, VLS again suggests that Your Worship recommend that the fire indicator panel be monitored at all hours.

It is apparent from the above discussion that the fire safety system is complicated and requires substantial co-ordination. Kew has a bad record in co-ordinating the system. VLS recognises the efforts made by Kew however VLS has fears that these improvements will not be long lasting and old patterns will re-emerge. VLS considers that the residents at Kew will be safer living in accommodation which is smaller and less in need of intricate technologies to provide safety.

PUBLIC AWARENESS OF FIRE ISSUES

VLS suggests Your Worship recommend that:
There be a public advertising campaign similar to that used for road safety to elevate fire safety awareness in the community.

By VLS' involvement in this inquest it has been conscientized to fire issues both in relation to persons who have an intellectual disability and generally. Not everyone has the opportunity to be involved in a lengthy coronial inquiry, and VLS identifies a need for fire awareness to be raised within the community.

A campaign on television will reach persons who have an intellectual disability as well as children and parents.

ORAL CULTURE.

VLS suggests Your Worship recommend that:
The Department develop strategies that will bridge the oral and written culture to ensure the actual dissemination of information ensuring real outcomes rather than a paper accountability of dissemination of information.

Kew staff operate on an oral culture. This has limitations in a place of this size in ensuring the transmission of information. Staff have shown they are not often aware what is in IPP files or GSPs or manuals. It is not a written culture.

The introduction of DISCIS is aimed to assist the dissemination of information. It, and other management systems that require staff to 'sign off' when they have read materials, is insufficient for staff at Kew who are used to an oral culture. Further many staff at Kew do not have English as their first language. They may not be confident in reading or writing English. KRS does provide literacy in English courses.

PHYSICAL ENVIRONMENT

VLS suggests that Your Worship recommends that:

People who have an intellectual disability, particularly those living at KRS, should, in order to minimise risk and ensure safety, live in accommodation which is consistent with Principles of the IDPS Act.

In particular we note that a physical environment consistent with these principles will be one which, amongst other things:

- supports a reasonable quality of life
- enhances an individual's capacity for development and for the exercise of maximum control over his or her life
- recognises the welfare of person with the intellectual disability as paramount
- reflects the norms and patterns which are values in the general community
- promotes maximum physical and social integration of the person with the intellectual disability in the life of the community
- promotes flexibility of service structures to meet the varying needs of intellectually disabled persons in developing towards independence and the maximisation of choices

We note that these Principles provide an appropriate and practical framework for balancing the rights of people with intellectual disabilities to a life of dignity and freedom, while also recognising the needs that might arise for an individual in view of his or her disability.

Consistent with these Principles, and with a commonsense approach to the minimisation of risk, VLS further suggests that an appropriate and safe physical environment will be one which:

- is uncramped by its configuration and furnishings, allowing easy movement throughout the building, and, when necessary, evacuation from it;
- is uncrowded, allowing residents to have their own rooms;
- provides numerous points of egress, including both doors and windows which can be easily opened in the event of an emergency.

We note that an institution such as KRS is not consistent with these Principles, nor with the commonsense implications of these noted above.

Renovating KRS to ensure such minimisation of risk will be costly, and we note that any funds spent on such renovations are funds spent on the maintenance of a facility with a necessarily limited life-span, and we therefore suggest that the thrust of Your Worship's recommendations should be towards the relocation of KRS residents into smaller settings throughout the community.

We suggest that Your Worship recommends that
The site at KRS be renovated to ensure that the risk minimisation features noted above obtain, to the greatest extent possible, for those residents who remain there.

Specifically, this will entail:

- drastically reduced numbers of residents per Unit
- renovations of Units to ensure that:
- bedrooms and living areas are of a size and configuration typical of what would be found in the community generally, with particular emphasis on issues of ease of flow and space
- all doors are able to be opened from inside
- windows can be opened and are unshuttered

HUMAN RESOURCE ISSUES

VLS submissions have identified serious flaws with the Department's management of the risk in relation to fire safety. The management system in place had the following features:

- it lacked accountability;
- it contributed to delay;
- it failed to ensure key staff were provided with necessary information

- those in head office were too removed from the 'coal face' to appreciate the urgency of the situation at KRS.

VLS suggests that Your Worship recommend the following to address these issues:
The Department appoint a person in head office who is responsible for fire safety in residential services for people who have an intellectual disability.

This person should have sufficient seniority to make budget allocations up to those amounts before which Ministerial or Cabinet approval must be sought.

This person should be responsible for:

- ensuring that residential services are allocated sufficient funds to conduct regular fire safety audits;
- ensuring that a standard form system for grading and prioritising fire risk is developed, and regularly reviewed;
- ensuring that a standard risk response action plan format is developed and regularly reviewed;

a risk response action plan must include:

- a grading as to priority;
- measures necessary to address the risk;
- a cost estimate;
- an outline of interim measures including recommendations in relation to additional staffing, re-location of residents, warnings and/or notification to key players of the risk;
- a time framework for review and endorsement of the plan and completion of measures necessary to address the risk;
- reviewing and endorsing risk response action plans;
- ensuring that funds are allocated to services to implement risk response action plans or interim measures
- seeking Ministerial or Cabinet approval for allocation of funds, where funds involved exceed his or her authority.

These responsibilities should not be able to be delegated.
The manager on location of any residential service for people who have an intellectual disability be made responsible for the fire safety system in place.

This means the manager is responsible for:

- reporting directly to the person in head office on all matters related to fire safety
- ensuring that fire safety audits are conducted on a regular basis, at least annually;
- ensuring that a risk response action plan is prepared in response to any risks identified through the audit process;
- ensuring that any risk response action plan with budgetary allocations which exceed his or her authority is forwarded to the person in head office identified above;
- following up and implementing any risk response action plan, including interim measures detailed in the plan;
- ensuring that the fire hardware system is regularly maintained. Maintenance intervals should be consistent with the manufacturer's recommendations in relation to the specific fire safety hardware in place;
- if maintenance contractors are involved, ensuring that the contractor's performance under the contract is satisfactory, and regularly reviewed;
- if other contractors or consultants are involved in upgrading the fire safety system, ensuring that the contractor's performance under the contract is satisfactory and regularly reviewed;
- ensuring that the residence or units in the residence have an evacuation plan which identifies any special needs of the residents;
- ensuring that evacuation plans are trialed and reviewed regularly;
- ensuring that evacuation plans are reviewed in response to any changes particularly changes in the condition or profile of residents, changes to staff or changes to the internal configuration of buildings or units;

- ensuring that residents are provided with the opportunity to learn about fire safety including evacuation procedures, self rescue and safety of others;
- ensuring that staff, particularly direct care staff have an appreciation of fire safety issues and risk management which they incorporate in their daily work. This includes ensuring that staff have appropriate training in fire safety and that the staff appraisal process assesses their understanding of risk management, including fire safety issues;
- ensuring that effective communication systems are in place which disseminate information about fire hazards, including residents who may be at risk of fire lighting behaviour, or who exhibit fire lighting behaviour;
- ensuring that appropriate individualised responses to residents who may be at risk of fire lighting behaviour, or who exhibit fire lighting behaviour are implemented.
- ensuring that where any capital works, modifications or renovations are contemplated, plans address the fire safety system and identify any fire risk association with the works.

These responsibilities should not be able to be delegated

This recommendation should apply to all managers irrespective of the number of residents in the service.

APPENDIX 3.8 THE OFFICE OF THE PUBLIC ADVOCATE RECOMMENDATIONS

GUIDELINES FOR SAFE HOUSING OF PEOPLE WITH DISABILITIES

Current and future residences for people with intellectual disabilities should be guided by the following safety guidelines:

(a) In recognition of the increased risk of fire and associated life-endangering phenomena posed by the characteristics of large congregate care residences, people with intellectual disabilities should be housed in units of a size comparable to domestic residences in the general community.

(b) Residences should be designed in recognition of the fact that the fewer residents, in general the safer the residence is for those residents.

(c) Maximum opportunity should be afforded to residents to optimise their own safety and to learn protective behaviours.

(d) Care for the residents should be provided so as to maximise the independence, autonomy and flexibility of residents so as to equip them to respond safely in relation to safety issues and particularly in the context of an emergency.

(e) Sufficient, individually tailored training should be provided to staff to enable them to maximise the independence, autonomy and flexibility of residents in respect of general life skills, which would equip them to respond safely in relation to safety issues and particularly in the context of an emergency.

(f) Sufficient information should be formally recorded by carers in relation to any particular dangers posed by residents so that such matters can be responded to promptly, appropriately and safely.

(g) Sufficient pertinent information about the current needs of particular residents and any safety issues arising out of recent incidents or behaviours should be provided during "handover" times between carers' shifts.

(h) Safety measures should be developed in conjunction with the Metropolitan Fire Brigade for individual residences in such a way as to maximise the independence, autonomy and flexibility of residents.

(i) Safety programmes should be developed in a way which is adapted to the particular behaviours, histories and disabilities of residents.

(j) Safety programmes should be developed in such a way as to minimise the potential for miscommunication and human error arising out of unnecessary complexity and inaction arising out of ambiguous allocation of responsibility.

(k) The structure of residences should optimise the degree of ingress and egress practicable for residents, particularly in circumstances of emergency, such as the need for urgent evacuation, taking into account the fact that residents are both voluntary occupants and persons in need of care.

(l) The size of a residence should be proportionate to the number of residents living within it because of the safety risks of large or inappropriately designed residences.

(m) Residences should be designed so as to enable proximity of carers to residents, consistent with the potential needs of residents in circumstances of emergency, and consistent with the residents' entitlement to privacy.

(n) Sufficient staff should be rostered, both during the day and at night, to respond adequately to individual residents in face of a threat to safety or an emergency.

(o) Staff should be trained sufficiently to respond to residents in circumstances of emergency.

(p) Hard copy resident profiles, accompanied by a reasonably recent photograph, together with relevant alerts, should be made easily accessible and read as a matter of standard procedure by any carers dealing with residents.

(q) Efforts should be made to optimise the continuity of care of residents, in recognition of the fact that carers accustomed to working with residents well-known to them are more likely to be attuned to developing circumstances of risk and danger.

(r) Evacuation protocols should be designed for each residence in a way that is tailored to the needs and level of disability of residents.

(s) Safety programs, including evacuation protocols, for residences should be designed in consultation with residents, carers, management, the Metropolitan Fire Brigade and other relevant agencies.

(t) Evacuation procedures should be practised at regular intervals, both at times during the day and at night, so that both staff and residents optimise the capacity of staff and residents to evacuate a residence in circumstances of emergency.

(u) Staff should receive regular (at least six monthly) training in emergency procedures and the use of first response fire equipment.

SPECIFIC SAFETY MEASURES TO BE INTRODUCED

The safety of current and future residences for people with intellectual disabilities should be supported by the following specific features:

(a) There should be hard-wired addressable smoke detectors in all rooms of all residences to maximise the early detection of fires.

(b) There should be residence-based alarms for all residences triggered by smoke detector activation to enable early warning to residents and staff of fires.

(c) There should be full sprinklering for all residences, where rapid evacuation is not possible, to maximise the potential for early extinguishment of fires.

(d) Fuel loads should be kept to levels consistent with safety.

(e) There should be an AIU facility to the Metropolitan Fire Brigade in all residences.

(f) There should be mimic panels in each residence to enable staff to ascertain speedily the location of activated smoke detectors.

(g) A masterkey system should exist in all residences for windows and doors.

(h) Automatic door strikes, operated by instigation of smoke detectors, should operate in all residences to enable speedy evacuation in circumstances of emergency.

(i) There should be adequate fire and smoke compartmentation within residences in accordance with the Building Code of Australia.

(j) Maps of the structure of residences should be prominently displayed within a prominent area of all residences, as recommended by the Metropolitan Fire Brigade.

(k) Maps of the structure of residences should be provided to the Metropolitan Fire Brigade.

MONITORING OF SAFETY

The safety of current and future residences for people with intellectual disabilities should be provided for on an ongoing basis in accordance with the following procedures:

(a) Sufficient auditing and monitoring processes, at regular intervals, should be employed to ensure that staffing levels are sufficient for residents' safety and that appropriate safety technologies have been installed in residences.

(b) Sufficient auditing and monitoring processes, at regular intervals, should be employed to ensure that the safety technologies installed in the residences continue to function at an acceptable level.

(c) Lines of responsibility for expeditious and sufficient upgrading of safety procedures and facilities at all residences housing people with intellectual disabilities should be clearly and simply specified.

IMPLEMENTATION

The following implementation processes should be constituted:

(a) A working group, consisting of representatives from the Department of Human Services, the Building Services Agency, Kew Residential Services, the Kew Parents' Association and the Office of the Public Advocate, should be established immediately to plan and implement the safe housing of people with intellectual disabilities in the care of the Department of Human Services.

APPENDIX 3.9 THE HEALTH AND COMMUNITY SERVICES UNION RECOMMENDATIONS

1.1 There should be a comprehensive review of staff/client ratios undertaken, in consultation with HACSU, KRS management, the Parent's Association, the MFB, and the fire detection and prevention contractors at KRS, to properly assess current staff needs, in the context of the present fire detection and prevention system.

1.2 Such a review should be on a unit by unit basis, taking into account, inter alia, the

- number and gender of clients in the relevant unit
- type and level of intellectual/psychiatric/physical disability
- range and gravity of challenging behaviour, in particular the risk to self, other clients and staff
- type of program and level of staff management required
- physical layout and environment of the unit
- equipment and disability aids available to staff
- existing fire detection and prevention system
- capacity to evacuate clients before conditions become untenable (i.e. in a matter of minutes) before buddies and /or the After Hours Coordination Team (AHCOT) may arrive to lend assistance
- classification of staff

1.3 Pending such a review there should be

- an immediate increase in night duty staff
- a reversal of the policy of amalgamation of units to the extent that two Deputy Unit Managers are employed per unit

1.4 Full 12 hour day and night shift hours should be maintained, with the most skilled and experienced staff member (i.e. the Deputy Unit Manager) participating in the shift handover. Handover times must be increased to enable night duty staff to fully appreciate any identified risk factors which may impact upon the health and safety of staff and/or clients over night.

1.5 Only active (i.e. non-sleeping) staff should be on night duty at all times, They must be able to concentrate on director care duties, in particular the supervision, monitoring, documentation and reporting of risk behaviour. Sufficient time must be allotted for comprehensive handover to day staff, so as to ensure that communication regarding client needs and risk behaviour is at an optimum and safe level, for the full 24 hour period, seven day per week.

1.6 In view of the reduced staff numbers at night, all night duty staff must at least have the classification of Intellectual Disability Service Officer.

2.1 All direct care staff at KRS should receive appropriate training in the specialty field of intellectual disability. Human Service Workers should be required to undergo the Advanced Certificate in Residential and Community Services (Intellectual Disability) or have an equivalent qualification.

2.2 All staff should receive training in the identification and management of clients who pose a fire risk.

2.3 Adequate replacement staff must be made available to permit staff to attend study or training.

2.4 All new staff must have a comprehensive induction and orientation.

2.5 Sufficient staff resources must be made available to enable all direct car staff to fully familiarise themselves with the contents of client files. Familiarisation and regular review must be carried out in a systematic way, to take account of staff rosters, transfers of staff or clients between units, and changes in staff due to holiday, sickness or turnover.

2.6 As staff may be called to attend an emergency in another unit at any time, each staff member must have an up to date knowledge of the physical layout of all units, and the appropriate fire evacuation procedures for each unit.

3.1 HACSU and staff must be consulted during the course of any fire audit.

3.2 All reports which touch upon the occupational health and safety of staff, in particular the contents of any fire audit reports, must be provided to HACSU and staff. Staff must have a full appreciation of the risks inherent in their working environment.

APPENDIX 3.10 THE KEW COTTAGES & ST. NICHOLAS PARENTS' ASSOCIATION RECOMMENDATIONS

THE STEPS THAT SHOULD BE IMPLEMENTED AT KRS

1. KRS to be the subject of a further fire audit and risk assessment.

2. All residential buildings should be fully sprinklered to appropriate Australian standards.

3. A comprehensive system of hard? wired smoke detectors, hard? wired thermal detectors and break? glass alarms should be installed throughout the facility in accordance with AS1670.

4. Every residential unit should have a local alarm system with:

   (a) an alarm bell; and

   (b) a local mimic panel;

   which identifies for carers (both within the unit and at the administration panel) the location of the detector in alarm.

5. The backup system of alarms in buddy units should be reprogrammed to ensure that the closest units to each affected building are on the same loop. The loops should be overlapping.

6. Fire and smoke compartmentation to BCA standards.

7. Egress to BCA standards.

8. Elimination of dead ends in accordance with the risk assessment (see point 1).

9. Automatic door unlocking devices connected to the fire detection system should be installed at each of the egress doors of the residential units.

10. A public announcement system dedicated to emergency communications should be installed throughout the complex.

11. Unit 7/8 is a continuing fire risk. Insufficient sprinklering and lack of an external fire escape should be addressed immediately and interim measures including extra staff should be adopted.

12. Fire fighting equipment to extinguish or contain spot fires should be installed in accordance with the Building Regulations in all units and be readily accessible at all times.

13. Such equipment should be regularly audited by the MFB.

14. In the construction of new, or the renovation of old, units, building standards at KRS must conform to the applicable building codes and fire regulations. Fire walls should separate adjoining flats and walls and ceilings should consist of fire resistant materials, wherever possible.

15. No building or renovation should be undertaken at KRS without first obtaining appropriate building permits.

16. All certified works to be inspected for compliance with certified plans prior to occupancy.

17. Design prior to construction should involve a full fire risk analysis and such analysis should involve consultation with the MFB.

18. The Building Control Commission should be encouraged to audit the existing buildings at KRS for compliance with the BCA.

19 Building certifiers should be provided with a full written brief by DHS regarding any renovation work conducted on the subject building within the previous five years and all other relevant information regarding prospective occupancy of the building.

20 DHS should report to Parliament in accordance with the guideline 5 of the Ministerial Guidelines of 1994.

21 The practice of locking all external and some internal doors at night should be further examined and reviewed to ensure the least restrictive approach for clients is adopted and that client evacuation is not compromised. A review of locked units generally must occur in relation to both doors and windows. This review should be conducted with consultation from the Parents' Association, the Community Visitors and the Public Advocates Office.

22 Each night staff member should carry a single master key at all times capable of opening all internal connecting, passage and external doors in all units. As foreshadowed by Ms McCartin, we understand that KRS will be moving to a single key system by June.

23. Every unit should have major exit doors with locks which automatically release when fire breaks out.

24. Illuminated exit lights and night lights should denote evacuation routes and assembly areas and MFB input should be obtained regarding the adequacy of such lighting.

25. The present system of one unit manager attempting to manage double units should be abandoned. No unit should exceed 20 clients and each unit must have a unit manager at MRN3 level.

26. The number of carers on duty in units during after hours periods should be increased, not only to cope with emergencies but also to ensure tighter checking and closer supervision of residents. Ratios should take into account residents' differing degrees of disability and special needs, such as challenging behaviour.

    Where any unit is divided into flats, it will be appropriate to have one carer per flat during the evening hours when clients may still be expected to be awake.

27. The AHCOT teams' duties and responsibilities should be reviewed in consultation with staff, HACSU and the Parents' Association to ensure sufficient staff are present for emergency situations at any time. It should be anticipated that newly installed alarm systems may present teething problems over the next 12 months. During that period the administration building and fire panel should continue to be manned at all times.

28. Handover time between shifts should be 30 minutes.

29. A consultative working party should be established to determine appropriate needs-based staffing levels on a unit by unit basis for day and night periods. Each unit should be assessed and such assessment should address minimum staff levels and minimum staff qualifications by way of a complete unit profile to be adhered to at all times.

    KRS staff, HACSU, the Parents' Association, Community Visitors and the Public Advocates Office should all be consulted for input into this process. The Consultation process should also address the availability of in-service training for KRS staff and should provide incentives for staff to undertake that training. Other issues to be addressed include handover, sleep over, use of casual staff, minimum qualifications for AHCOT, English language proficiency and the impact on staff capacity to supervise clients of non-direct care chores such as laundry and unit based cooking etc.

30. A specified minimum standard of induction should be performed prior to any staff commencing duty in a direct care role.

31. Strategies to reduce staff turnover should also be considered. Bearing in mind staff turnover, no staff member should be employed in a direct care role until they have been fully oriented.

32. A Chief Fire Warden (answerable to the CEO) should be responsible for all aspects (physical and human) relating to fires and emergencies, fire prevention and policy development at KRS. Safety training and evaluation

of fire systems would be among the tasks of this position with regular consultation with management and a fire committee.

It is acknowledged that since the fire Ms McCartin has assumed overall responsibility for all aspects of fire prevention, both facilities and direct care, and that her deputy may have a portfolio similar to the Fire Warden position described above.

33. A fire safety committee is necessary with personnel from the facilities and direct care streams and input form all levels of staff, management, AHCOT and the Parents' Association. It is acknowledged that the Fire Safety Committee at KRS has been reconvened and it is hoped that the committee will address all risk management issues including fire incidents or near misses at KRS, appropriateness of evacuation plans, publication of fire alert bulletins, submissions to management and AHCOT regarding staffing adequacy, funding submissions and matters raised by the KRS MFB Liaison Committee and the Parents' Association.

34. A greater degree of access to information as to renovations and fire prevention measures should be provided to the Parents' Association for discussion at liaison meetings.

    Parents should be represented on the Fire Committee.

    There should be ongoing and continuous participation of the Parents' Association in the management process at KRS.

    The Parents' Association should have access to all health and safety reports for KRS.

35. A central unit should be created from within DHS to co?ordinate fire risk awareness in residential facilities throughout Victoria and to develop training materials which staff could use.

36. It is acknowledged that greater liaison will occur between the MFB and KRS regarding fire training and fire awareness. We hope this will be an enduring process with regular MFB audits of individual units.

37. KRS should adopt emergency evacuation procedures in accordance with AS3745.

38. A comprehensive training program, should be instituted in collaboration with the Metropolitan Fire Brigade so that all staff caring for residents become proficient in the theory and practice of fire safety and evacuation procedures.

39. The full range of modern training techniques for group and individual instruction must be examined, including lectures, films, videos, drills, computer modelling and group discussion. We note that fire response issues are currently being addressed to some degree.

40. Every member of a buddy unit should be informed thoroughly as to client behaviours, client identification and the geographic layout of adjacent units (including regular tours). Every unit should be manned at night by at least one staff member who has received fire warden training. We understand that there is now a greater degree of buddy orientation provided and this should continue.

41. Consideration should also be given to offering special incentives to undergo additional training.

42. Fire drills and evacuations should be carried out regularly day and night. Every direct care staff member should participate. The MFB should be asked to observe such drills on a regular basis and records of all drills should be maintained.

43. A specified appropriate minimum standard of orientation in fire safety should be required before staff commence duty.

44. Several copies of client and client profile lists should be placed in various selected places around the Units (office, each flat and in an external fire box on the wall of the building) so that lists are easily accessible.

45. It is acknowledged that improvements have been made to enable clients to be more quickly identified and accounted for in the case of an emergency evacuation. This practice should continue.

46. Staff should have fire risk awareness training and be trained in controlling the use by clients of cigarette lighters and matches. Staff should also be provided with and trained in the use of fire safety equipment including hydrants and hoses. Such fire safety equipment should also be the subject of regular safety audits.

47. Strategies should be implemented to cope with fire-lighting behaviour and other types of challenging behaviour likely to endanger other people.

48. All direct care staff should be required to be informed of the relevant portions of GSPs, IPPs and client profiles of all residents in their charge and to implement recommendations contained therein.

49. Direct care staff should be required to identify to their line supervisor potential fire lighting or fire risk behaviour.

50. Each unit manager should be required to identify all clients with any past or present fire lighting or fire risk behaviours or propensities.

51. Hard copy client profiles with a photo and all relevant alerts should be made easily accessible and compulsorily read by all staff.

52. A full review of the fire protection maintenance contracts at KRS should be urgently performed by DHS, KRS management and the KRS Fire Committee.

53. There should be one maintenance contractor for all residential buildings at KRS.

54. The maintenance contract should be directly with KRS and should be overseen by the CEO, Chief Fire Warden and the Fire Committee.

55. Funding for the maintenance contractor should be reviewed after consultation with the appointed fire auditor.

56. Quality control (and auditing for compliance with Australian standards) of the fire maintenance contractor should be conducted by KRS, the Chief Fire Warden and the Fire Committee with regular input from the MFB and a properly appointed fire engineer.

57. DHS should investigate whether the person appointed to conduct the future fire audit of KRS should also be invited to conduct a general audit of other DHS facilities.

58. DHS should investigate the feasibility of contracting a fire safety engineer for all DHS facilities to provide expert assistance on fire engineering issues (including maintenance practices) on an ongoing basis.

59. All fire prevention maintenance should be conducted in accordance with the Australian standards and the Building Regulations should also be adhered to regarding maintenance of fire safety systems.

60. The Parents' Association is very disturbed by the fact that Jonkar Pty Ltd has recently "upgraded" unit 24, has been considered for unit 23 and is responsible for the ongoing maintenance of unit 24. Concerns relate to the competence of Jonkar Pty Ltd generally as well as the problems which may arise from having dual maintenance contractors on the site and often operating from the one fire panel.

61. A process for DHS to maintain a register of approved consultants for minor and major works should be developed.

62. All consultants should be provided with all relevant reports and information to ensure they are able to perform their specified function.

63. In relation to all coronial inquests (and specifically the Kew Cottages Coronial Inquest), DHS should establish a formal structure to:

    (a) consider the Coroner's findings;

    (b) implement the Coroner's recommendations; and

    (c) monitor progress in relation to implementation of recommendations.

64. Systems must be established to ensure the smooth transfer of knowledge and information and the continuation of operational functioning notwithstanding staff and management turnover.

APPENDIX 4 RESPONSES TO RECOMMENDATIONS OF PARTIES ON FIRE SAFETY

4.1 Introduction to Appendix 4

4.2 The State of Victoria (and the Department of Human Services) Response to Parties' Recommendations

4.3 Villamanta Legal Service Response to Parties' Recommendations

APPENDIX 4.1 INTRODUCTION TO APPENDIX 4

Some of the recommendations made by several parties involved in the inquest have been examined by the State of Victoria and Villamanta Legal Service.

The State of Victoria has agreed with a large number of the recommendations of the parties. However, a lack of sufficient time has meant that the State has not been able to examine some of the recommendations in any detail.

The Villamanta Legal Service has also undertaken considerable work to examine the parties' recommendations. That work is contained in Appendix 4.3. It is noted that the legal service did not examine the State's recommendations as they were not available at the time that it completed the submissions. Further, the BSA's impressive work on its 'Vision' was not available for comment by the legal service.

APPENDIX 4.2 THE STATE OF VICTORIA (AND THE DEPARTMENT OF HUMAN SERVICES) RESPONSE TO PARTIES' RECOMMENDATIONS

The State of Victoria makes the following submissions in response to the recommendations made by other parties to the Inquest.

It should be noted that given the breadth of the recommendations made, it is impossible for the State of Victoria to address each recommendation in detail. Any failure to respond to a specific recommendation made by a party ought not to be taken as a recognition that the proposed recommendation is agreed to by the State of Victoria.

A. KEW PARENTS' ASSOCIATION SUBMISSION

The State of Victoria makes the following submissions with respect to the recommendations made by the Parents Association in Appendix D of their submission.

1. FIRE DETECTION AND PREVENTION

1. KRS to be subject of a further fire audit and risk assessment.

Agreed. As noted in paragraph 2.48 of the Fire Safety Improvements section of this submission, KRS will be the subject of a further fire audit and risk assessment. Warrington Fire Research Pty Ltd ("the consultant") has been appointed to undertake the review, which is to be completed within three months.

2. All residential buildings should be fully sprinklered to appropriate Australian standards.

Disagree. As noted in response to recommendation one, a consultant has been appointed to review the fire protection system at KRS. The consultant has been requested to examine the issue of whether the sprinkler system should be extended.

3. A comprehensive system of hard-wired smoke detectors, hard-wired thermal detectors and break-glass alarms should be installed throughout the facility in accordance with AS1670.

Disagree. KRS already has a comprehensive fire protection system installed. The consultant appointed to review the fire protection system at KRS has been requested to advise on the issue of enhancement of the fire detection and suppression system and the Department of Human Services will consider the recommendations made.

4. **Every residential unit should have a local alarm system with:**

   (a) an alarm bell; and

   (b) a local mimic panel;

   which identifies for carers (both within the unit and at the administration panel) the location of the detector in alarm.

   Disagree. See response to recommendation 3.

5. **The backup system of alarms in buddy units should be reprogrammed to ensure that the closest unit to each affected building are on the same loop. The loops should be overlapping.**

   Disagree. The consultant appointed to review the fire protection system at KRS has been requested to advise on the issue of evacuation procedures and general fire administration and the Department of Human Services will consider the recommendations made.

6. **Fire and smoke compartmentation to BCA standards.**

   Disagree. As for recommendation 3.

7. **Egress to BCA standards.**

   Disagree. As for recommendation 3.

8. **Elimination of dead ends in accordance with the risk assessment (see point 1).**

   Disagree. The consultant appointed to review the fire protection system at KRS has been requested to advise on the issue of egress routes and the Department of Human Services will consider the recommendations made.

9. **Automatic door unlocking devices connected to the fire detection system should be installed at each of the egress doors of the residential units.**

   Disagree. The consultant appointed to review the fire protection system at KRS has been requested to advise on the issue of automatic door strikes and the Department of Human Services will consider the recommendations made.

10. **A public announcement system dedicated to emergency communications should be installed throughout the complex.**

    Disagree. The current fire safety system has a number of both visual and auditory cues to alert staff to take action. These include: break glass alarms, local alarm bells to indicate there is an alarm in the unit and strobe lights and hooters to alert buddies within a loop to respond.

    These mechanisms are seen as an effective way to alert staff for the need to respond in an emergency. In the event of a non fire emergency, these mechanisms are still available because staff can break the glass alarm to trigger off the reaction of the alarms, link to the MFB through the AIU and alert buddies to come and assist. Notwithstanding this, the expert who has subsequently been engaged to provide a review of the system has been asked, inter alia, to review the communication system and advise whether any enhancements can be made.

11. **Unit 7/8 is a continuing fire risk. Insufficient sprinklering and lack of an external fire escape should be addressed immediately and interim measures including extra staff should be adopted.**

    Agreed. As noted in section 5 of the Fire Safety Improvements section of this submission, Unit 7/8 will be fully sprinklered pending its closure.

2. FIRE EQUIPMENT

12. **Fire fighting equipment to extinguish or contain spot fires should be installed in accordance with the Building Regulations in all units and be readily accessible at all times.**

    Agreed. Fire fighting equipment at KRS meets the requirements of the Building regulations.

13. Such equipment should be regularly audited by the MFB.

Agree in part. As outlined in the Fire Safety Improvements section of this submission, section 2J, the new maintenance contract being developed for the Department's Training Centres will include a regular audit of all fire protection equipment.

3. ELIMINATION OF FIRE HAZARDS

14. In the construction of new, or the renovation of old, units, building standards at KRS must conform to the applicable building codes and fire regulations. Fire walls should separate adjoining flats and walls and ceilings should consist of fire resistant materials, wherever possible.

Agreed. The Building (Further Amendment) Act 1997 has recently amended the Building Act 1993 to require government buildings to comply with the Act and the Regulations. It is anticipated that the amendment will be proclaimed on 1 August 1997. From this time all building and renovations at KRS will comply with applicable building codes and fire regulations. The State of Victoria supports the use of fire resistant material in the construction of buildings. It notes that there is little guidance in the Australian Standards on the use of such material.

15. No building or renovation should be undertaken at KRS without first obtaining appropriate building permits.

Agreed. As noted in response to recommendation 14, works at KRS will comply with the Building Act 1993 and Regulations.

16. All certified works to be inspected for compliance with certified plans prior to occupancy.

Agreed. All plans and works will need to comply with the Building Permit process. This requires a building surveyor to provide documentation to prove the works have been constructed in accordance with Building regulations. The Department of Human Services will obtain permits for all capital works which require them.

17. Design prior to construction should involve a full fire risk analysis and such analysis should involve consultation with the MFB.

Agreed. The Department of Human Services requires a fire engineer to be included on design teams for all new work so that designs can be assessed for fire safety.

18. Building Control Commission should be encouraged to audit existing buildings at KRS for compliance with the BCA.

Disagree. The BCC does not undertake audits of any existing buildings under the Building Act. This is the responsibility of local councils via their Municipal Building Surveyor under Section 212 of the Act. The BCC is presently assisting a pilot program with the CFA and City of Casey to establish an appropriate risk based methodology for auditing of buildings within each municipality.

As outlined in section 2 of the Fire Safety Improvements section of this submission, under the Department's Fire Risk Management Strategy the Department will undertake a complete fire audit on all its existing buildings. This risk assessment will verify the buildings' compliance with the performance based Building Code of Australia to be introduced in August this year.

19. Building certifiers should be provided with a full written brief by DHS regarding any renovation work conducted on the subject building within the previous five years and all other relevant information regarding prospective occupancy of the building.

Disagree. The Department of Human services does not believe it is necessary for such a practice to be adopted. Building Certifiers are required to assess a building for suitability for a particular occupancy. The history of the building is not relevant. What is important is the state of the building at the time of assessment.

20. DHS should report to Parliament in accordance with Guideline 5 of the Ministerial Guidelines of 1994.

Agreed. The Department is currently undertaking a standards and conditions audit of all facilities for the purpose of reporting to Parliament under this guideline. It is anticipated that the report will be incorporated into the 1996/97 Annual Report.

4. LOCKED DOORS

21. The practice of locking all external and some internal doors at night should be further examined and reviewed to ensure the least restrictive approach for clients is adopted and that client evacuation is not compromised. A review of locked units generally must occur in relation to both doors and windows. This review should be conducted with consultation from the Parents' Association, the Community Visitors and the Public Advocates Office.

Agreed in part. Locked Units at KRS have been progressively decreased over the past five years. In 1992 there were 274 people in locked Units. In 1997 there are 100 people in Units which are locked for all or part of the time. This has been a result of:

- Improvements in clients living environment, specifically the introduction of the flats,
- Introduction of fencing to create front and back yards,
- Improved behaviour management,
- Regrouping clients.

Only internal doors which are not required to be accessed, eg store rooms, are locked at night. That is, all interconnecting doors that lead to egress points and/or between flats, are specifically required to be unlocked during the night.

The practice of locking doors is subject to constant review. All Units are encouraged to identify ways that the locking of doors can be decreased, or eliminated during the day. The expert consultant engaged to review the fire safety systems has been asked to investigate the appropriateness of installing door strikes. Pending the outcome of this review, KRS will, at a minimum, ensure that all exit doors swing outwards. In addition, the single master key system also improves access to the units for all staff, both day and night.

22. Each night staff member should carry a single master key at all times capable of opening all internal connecting, passage and external doors in all units. As foreshadowed by Ms McCartin, we understand that KRS will be moving to a single key system by June.

Agreed. KRS has now moved to a single master key system.

23. Every unit should have major exit doors with locks which automatically release when fire breaks out.

Disagree. As noted in response to recommendation 21, the consultant appointed to undertake the fire systems review will be asked to advise on this issue. See also the Department's response to OPA's recommendation (h) under specific safety Measures to be Adopted.

24. Illuminated exit lights and night lights should denote evacuation routes and assembly areas and MFB input should be obtained regarding the adequacy of such lighting.

Disagree. It would be inappropriate to install illuminated lights on evacuation routes at KRS prior to the review of the fire protection system noted in the response to recommendation one. Illuminated exit lights exist within units currently, and the MFB has been consulted regarding the implementation of flashing lights to denote assembly points. Portable flashing lights are now stored in the evacuation packs and will be used to denote warden location and assembly points.

5. STAFF CLIENT RATIOS

25 The present system of one unit manager attempting to manage double units should be abandoned. No unit should exceed 20 clients and each unit must have a unit manager at MRN3 level.

Disagree. Amalgamations of "double units" as they are known occurred in 1994. The system whereby Unit Managers manage larger (or double) units is considered to have worked effectively. Issues which were experienced in the early stages of the amalgamation have subsequently been addressed. Unit Managers across KRS are supported by their Sector Manager, with whom they can discuss both work load and priority issues on a regular basis.

The number of clients in each unit varies from approximately 25 to 48. Units with a larger client population have additional Deputy Unit Manager support. The proposal that Unit Managers have a maximum of 20 clients is neither financially feasible, nor does it make greatest use of the seniority of the Unit Manager position.

It should be noted that the number of clients on the site is decreasing overall. The Minister for Youth and Community Services, the Hon Denis Napthine recently announced that 58 clients will move into community accommodation. Following on from this, the two double storey units (Unit 1 and Unit 7/8) will close. The number of clients on the site, and therefore in individual units, is decreasing on a progressive basis and the number of clients in each unit is reviewed on a regular basis.

26. The number of carers on duty in units during after hours periods should be increased, not only cope with emergencies but also to ensure tighter checking and closer supervision of residents. Ratios should take into account residents' differing degrees of disability and special needs, such as challenging behaviour.

Where any unit is divided into flats, it will be appropriate to have one carer per flat during the evening hours when clients may still be expected to be awake.

Disagree. The number of carers on duty at night is considered sufficient to enable the checking and supervision of residents to occur, as per the requirements of KRS and the Departmental Instruction regarding Active Night Duty. This instruction requires that all residents are checked, at a minimum hourly. At KRS, the checking requirements have been increased and all clients are required to be checked half hourly. The current ratios allow these supervision requirements to be met.

Furthermore the fire safety system, including the buddy system, was based on the existing staff:client ratios. In addition to the Unit based staff, staff from the AHCOT Team are available to assist with specific client issues and/or emergencies throughout the night. The advice from fire safety experts also confirms that additional staffing is not the critical factor in ensuring the safety of clients.

27. The AHCOT teams' duties and responsibilities should be reviewed in consultation with staff, HACSU and the Parents' Association to ensure sufficient staff are present for emergency situations at any time. It should be anticipated that newly installed alarm systems may present teething problems over the next 12 months. During that period the administration and fire panel should continue to be manned at all times.

Disagree. The AHCOT system provides sufficient staff for emergency situations at any time. Discussion with the Parents' Association and HACSU already occurs through monthly meetings which discuss a range of issues, including fire safety. KRS will request the Consultant reviewing the fire protection system to advise on how the night communication system can be enhanced to ensure maximum information is relayed via phone or pager to the AHCOT staff and to Unit staff via the Panel.

28. Handover time between shifts should be 30 minutes.

Disagree. Handover time in units has been extended to 15 minutes, which in a largely stable environment allows sufficient time for a proper handover of duties and information exchange to take place. As noted in evidence by Bonnie Tosevski, staff do not leave until handover has been completed appropriately.

29. A consultative working party should be established to determine appropriate needs-based staffing levels on a unit by unit basis for day and night periods. Each unit should be assessed and such assessment should address minimum staff levels and minimum staff qualifications by way of a complete unit profile to be adhered to at all times.

KRS staff, HACSU, the Parents' Association, Community Visitors and the Public Advocates Office should all be consulted for input into this process. The Consultation process should also address the availability of in-service training for KRS staff and should provide incentives for staff to undertake that training. Other issues to be addressed include handover, sleep over, use of casual staff, minimum qualifications for AHCOT, English language proficiency and the impact on staff capacity to supervise clients of non-direct care chores such as laundry and unit based cooking etc.

Disagree. The staffing levels provided to each unit are established and reviewed on a regular basis to ensure the appropriate standards of care are provided.

KRS employs suitably qualified, experienced and skilled management staff to undertake the day to day running of the facility, lead major redevelopment and develop both short, medium and long term plans. Where appropriate KRS management provide information and discuss proposals with a range of relevant stakeholders, such as advocacy groups, the MFB, or the Parents' Association and HACSU. It would not be appropriate however to set a specific protocol or requirement around all such consultation as such consultation should be an active and relevant process whereby management seek out the specific information they require in order to make the necessary decisions.

30. A specified minimum standard of induction should be performed prior to any staff commencing duty in a direct care role.

Agreed. All new staff at KRS are required to attend a one day pre service orientation session which familiarises them with the Centre and its systems. On commencement of employment staff are also required to undertake unit orientation within the Unit in which they work. This orientation includes emergency procedures. KRS has recently reviewed this orientation process and developed a check list for all new staff.

All direct care staff, both Human Service Workers and qualified, are required to undertake a mandatory induction program within 6 months of their employment. Human Service Workers undertake a 9 day induction program. Qualified, ie MRNs or IDSOs undertake a 3 day program.

31. Strategies to reduce staff turnover should also be considered. Bearing in mind staff turnover, no staff member should be employed in a direct care role until they have been fully oriented.

Agree. The Department of Human Services believes that staff turnover at KRS is not comparatively high. KRS strives to maintain both a consistent and high quality work force at all times. KRS has and will continue to explore strategies to reduce absenteeism, maintain quality staff and address poor performance. A number of strategies have been put in place to deal with this, including the introduction of a staff appraisal system, and the introduction of a formal reward system, known as "KRS Long Service and Achievement Awards". One particular achievement award was for staff attendance and a long service awards celebrated staff members' long term commitment to KRS residents. As per the recommendation, it is agreed that staff members should receive orientation prior to undertaking direct care.

6. ORGANISATIONAL STRUCTURE

32. A Chief Fire Warden (answerable to the CEO) should be responsible for all aspects (physical and human) relating to fires and emergencies, fire prevention and policy development at KRS. Safety training and evaluation of fire systems would be among the tasks of this position with regular consultation with management and a fire committee.

Disagree. As noted in Section 20 of the Fire Safety Improvements section of this submission, the responsibility for local fire safety is with the Manager, KRS.

33. A fire safety committee is necessary with personnel from the facilities and direct care streams and input from all levels of staff, management, AHCOT and the Parents' Association.

Agreed in part. As noted in Section 9 of the Fire Safety Improvements section of this submission, the KRS/MFB Liaison Committee was established in 1997. All Training Centres will establish similar committees. The Parents' Association can identify issues with the Manager, KRS for consideration by the Committee and receive feedback through its monthly meeting with KRS management.

34. A greater degree of access to information as to renovations and fire prevention measures should be provided to the Parents' Association for discussion at liaison meetings.

Parents should be represented on the Fire Committee.

There should be ongoing and continuous participation of the Parents' Association in the management process at KRS.

The Parents' Association should have access to all health and safety reports for KRS.

Agreed in part. KRS management meets with the Parents Association on a monthly basis, at meetings known as KRS/Parents Association Liaison Meetings. KRS is happy to provide information on renovations, fire safety and other change initiatives to the Parents Association at these meetings.

With respect to the parents representation on the Fire Committee, this is not considered appropriate as the Fire Committee is an operational committee involving staff from a cross section of Kew. It is important that this committee is able to discuss matters in an open and frank manner as staff are involved and for management to draw from this strategies for improvements. However, the outcomes of the committee meetings can be provided to the Parents Association in greater detail at the KRS/Parents' Association Liaison Meetings if requested.

35. A central unit should be created from within DHS to coordinate fire risk awareness in residential facilities throughout Victoria and to develop training materials which staff could use.

Agreed in part. As noted in section 2 of the Fire Safety Improvements section of this submission, a Fire Risk Management Strategy Committee will be formed with representation from each Division to overview the implementation of the Fire Risk Management Strategy implemented by the Department. In addition the Human Resources Branch of the Department's Corporate Resources Division (which is responsible for the co-ordination of all staff development and training across the Department) will develop appropriate staff training.

36. It is acknowledged that greater liaison will occur between the MFB and KRS regarding fire training and fire awareness.

As outlined in the Fire Safety Improvements section of this submission in sections 9 and 10, greater involvement exists with the MFB due to the liaison committee, and the role of the MFB in evaluating and observing fire evacuations and drills.

37. KRS should adopt emergency evacuation procedures in accordance with AS3745.

Agreed in part. KRS now has an efficient set of evacuation procedures, which largely comply with AS3745. KRS will consult with the MFB through the KRS/MFB Liaison Committee and seek their advice on compliance with the standards.

38. A comprehensive training program, should be instituted in collaboration with the Metropolitan Fire Brigade so that all staff caring for residents become proficient in the theory and practice of fire safety and evacuation procedures.

Agreed. It is now a requirement, set out in the KRS fire manual, that units must complete six drills per annum, including at least two night drills. The MFB has also been requested to observe seven day and night drills over the next nine months. These measures are set out in detail in section 10 of the Fire Safety Improvements section of this submission.

As outlined in Section 11 of the Fire Safety Improvements section of this submission, between April 1996 and April 1997, 26 fire safety and response training sessions were conducted and 438 staff were trained. The training program is ongoing.

A system of refresher training for all staff is being developed by KRS, including ways of practising the "methods of rescue" component of the training. This will include increasing the complexity of drills and also discussing the fire warden's role and evacuation scenarios at unit meetings. Unit Managers, Sector Managers and the After Hours Co-ordination Team have also participated in the advanced fire safety training.

39. The full range of modern training techniques for group and individual instruction must be examined, including lectures, films, videos, drills, computer modeling and group discussion. We note that fire response issues are currently being addressed to some degree.

Agreed. The Department of Human Services' response to training on all issues encompasses the full range of modern training techniques.

40. Every member of a buddy unit should be informed thoroughly as to client behaviours, client identification and the geographic layout of adjacent units (including regular tours). Every unit should be managed at night by at least one staff member who has received fire warden training.

Agreed in part. KRS management has already initiated buddy orientation as outlined by Francene McCartin in evidence. This involves buddies within each loop both day and night visiting neighbouring units to become familiar with both the layout and the client population.

All night staff at KRS have received Fire Safety Response Training. As the Fire Warden role is undertaken by AHCOT at night, not Unit night staff, all AHCOT staff have undertaken Fire Warden Training. As noted in response to recommendation 5, this matter will be referred to the consultant appointed to review the fire protection system.

41. Consideration should also be given to offering special incentives to undergo additional training.

Disagree. Fire Safety and Response Training and Fire Warden Training is compulsory for all staff, so the question of incentive is unnecessary.

For other forms of training back fill is required. This enables staff to be free to attend training without placing additional pressure on their co-workers within their unit. Incentives beyond this are not considered necessary as staff are prepared to attend training and are supported by management to do this.

42. Fire drills and evacuations should be carried out regularly day and night. Every direct care staff member should participate. The MFB should be asked to observe such drills on a regular basis and records of all drills should be maintained.

Agreed. As noted in the response to recommendation 38, units must complete six drills per annum, including at least two night drills. All drills are evaluated and records kept. The MFB has also been requested to observe seven day and night drills over the next nine months. These measures are set out in detail in section 10 of the Fire Safety Improvements section of this submission.

43. A specified appropriate minimum standard of orientation in fire safety should be required before staff commence duty.

Agree. In February 1995 a mandatory seven day induction program was established for HSWs. Since July 1995, all HSWs have been required to attend the induction program within six months of their employment. These staff also have access to an extensive range of in service courses organised by the Disability Services Training Unit (DSTU). As noted in the response to recommendation 30, all staff receive a day of pre-service orientation and Unit orientation on commencement which includes emergency procedures.

44. Several copies of client and client profile lists should be placed in various selected places around the Units (office, each flat and in an external fire box on the wall of the building) so that lists are easily accessible.

As noted in Section 12 of the Fire Safety Improvements section of this submission, client lists have been updated, include photo identification, and are kept in evacuation packs, the clients' file and centrally at the administration building.

45. It is acknowledged that improvements have been made to enable clients to be more quickly identified and accounted for in the case of an emergency evacuation. This practice should continue.

Agreed. It will.

46. Staff should have fire risk awareness training and be trained in controlling the use by clients of cigarette lighters and matches. Staff should also be provided with and trained in the use of fire safety equipment including hydrants and hoses. Such fire safety equipment should also be the subject of regular safety audits.

Agreed. As noted in the Fire Safety Improvements section of this submission the Disability Services Policy Statement has been distributed on a statewide basis. This document alerts all staff to be aware of fire risk behaviour. Training staff in "controlling the use by clients of cigarette lighters and matches" is a limited solution to a more complex issue. As outlined in sections 4 and 11 of the Fire Safety Improvements section of this submission, all staff have been alerted to be aware of fire risk, and provided with resources to enable assessment and appropriate response to fire risk behaviours.

8. CHALLENGING BEHAVIOURS

47. Strategies should be implemented to cope with fire-lighting behaviour and other types of challenging behaviour likely to endanger other people.

Agreed. As outlined in section 3 of the Fire Safety Improvements section of this submission, the Disability Services Policy Statement provides a range of strategies to address fire-lighting behaviour.

48. All direct care staff should be required to be informed of the relevant portions of GSPs, IPPs and client profiles of all residents in their charge and to implement recommendations contained therein.

Agreed. As outlined in the Fire Safety Improvements section of this submission section 22, improvements have been put into place to ensure the relevance and appropriateness of GSPs and IPPs. Initiatives to ensure that direct care staff are aware of relevant documents include:

- The Assessment of Needs and GSP training for Unit Managers and Deputy Unit Managers;
- a complete revision of the key worker system, with an emphasis on staff roles and responsibilities in relation to IPPs;
- discussion of an individual client's IPP at the monthly unit meeting; and
- quality control mechanisms including a "bring up" system to ensure GSPs are completed on time and random audits of client files.

49. Direct care staff should be required to identify to their line supervisor potential fire lighting or fire risk behaviour.

Agreed. This already occurs through the Department of Human Services' incident reporting policies. Where any client is involved in an incident related to firelighting behaviour an incident report must be completed. As outlined in section 22 of the Fire Safety Improvements section of this submission, this was advised to staff in December 1996.

50. Each unit manager should be required to identify all clients with any past or present fire lighting or fire risk behaviours or propensities.

Agreed. As part of the Disability Services Branch Policy Statement on Fire Risk Behaviour all direct care managers, including units managers, are required to complete a check list to identify clients with fire lighting or fire risk behaviours. This check list is currently being completed for all clients at KRS and will be updated on a regular basis, ie 12 monthly, as part of the Assessment of Need process. In the event that any clients are identified as having risk behaviours, appropriate action plans will be put in place through the IPP process in consultation with the Eastern Metropolitan Fire Risk Action Group which has the involvement of the MFB Juvenile Fire Awareness program and consultancy through Professor Robert Alder of the Royal Children's Hospital.

51. Hard copy client profiles with a photo and all relevant alerts should be made easily accessible and compulsorily read by all staff.

Agreed. As noted in section 12 of the Fire Safety Improvements section of this submission, Client Identification Cards with a photo of the client and all relevant details, including Alerts, Next of Kin, likes, dislikes, nature of disability, etc. have been introduced to KRS. Three copies of the cards are available. One copy is kept in the Evacuation Pack along with the Master List, the second copy is held centrally in the Administration Building for access by Management and/or AHCOT and the third copy is placed on the client's file. It is agreed that this card should, as a matter of policy, be compulsory reading for all staff.

55. Funding for the maintenance contractor should be reviewed after consultation with the appointed fire auditor.

Agreed. The specifications for the consultant undertaking the review of the Fire Safety System includes involvement in establishment of the Fire Safety Maintenance Contract outlined in section 2J of the Fire Safety Improvements section of this submission.

B. VILLAMANTA LEGAL SERVICE SUBMISSION

The State of Victoria makes the following submissions with respect to the recommendations made by Villamanta Legal Service in section 9 of their submission (page 71).

9.2.1 That until a technical solution is found the Department should ensure that the fire indicator panel is constantly monitored by a staff member.

Agreed in part. As noted in the response to the Kew Parents' Association recommendation 27, the AHCOT system provides sufficient staff for emergency situations at any time. KRS will request the Consultant reviewing the fire protection system to advise on how the night communication system can be enhanced to ensure maximum information is relayed via phone or pager to the AHCOT staff and to Unit staff via the Panel.

9.2.2 That all staff receive regular instruction and familiarisation with the fire detection system. In the induction of new staff there must be training and familiarisation.

Agreed. As outlined in section 11 of the Fire Safety Improvements section of this submission, on the request of KRS, Wormalds have conducted training on the Fire Safety System including use of the fire panel. To date, 16 sessions have been held - providing training to 106 staff. Regular "Fire Panel" training will continue to be scheduled. As part of the management audit role of AHCOT , Unit staff are asked questions relating to their knowledge of the fire panel as part of regular audits carried out by AHCOT.

It is now a requirement, set out in the KRS fire manual, that units must complete six drills per annum, including at least two night drills. The MFB has also been requested to observe seven day and night drills over the next nine months. These measures are set out in detail in section 10 of the Fire Safety Improvements section of this submission.

As outlined in Section 11 of the Fire Safety Improvements section of this submission, between April 1996 and April 1997, 26 fire safety and response training sessions were conducted and 438 staff were trained. The training program is ongoing.

A system of refresher training for all staff is being developed by KRS, including ways of practising the "methods of rescue" component of the training. This will include increasing the complexity of drills and also discussing the fire warden's role and evacuation scenarios at unit meetings. Unit Managers, Sector Managers and the After Hours Co-ordination Team have also participated in the advanced fire safety training.

9.2.3 That staff be made aware of the limitations of the fire sprinkler system and that the sprinkling of the double storey unit be extended to cover the entire premises.

Agreed in part. It is not acknowledged that the current system of sprinklers has limitations. When the new Fire Safety System was implemented in June 1995, a briefing was held for Unit Managers and staff were oriented to the new system. In addition, the KRS Fire Manual which is compulsory reading for all staff, provides an overview of the Fire Safety System, including the features of the system such as local alarms, sprinklers, thermal heat detectors and direct connection to the MFB.

Unit 7/8 has recently been reviewed and on the advice of the expert consultant will have the sprinkler system extended. Unit 1, which is the only other double storey unit, already has sprinklers in the downstairs area, as there are bedrooms downstairs and therefore both upstairs and downstairs are sprinkled.

The Minister for Youth and Community Services, the Hon Denis Napthine, recently announced the closure of these two units. Notwithstanding the closures the extension of the sprinklering of Unit 7/8 will occur pending closure.

9.2.4 The Coroner be kept informed about the technical developments despite the ending of the inquest.

This is a matter which it is appropriate for the Coroner to consider, but the State of Victoria makes no submission as to this recommendation.

9.3 PUBLIC AWARENESS OF FIRE ISSUES.

9.3.1 There be a public advertising campaign similar to that used for road safety to elevate fire safety awareness in the community.

This matter is within the purview of the MFB, but it is understood that such a campaign already exists.

9.4 ORAL CULTURE.

9.4.1 The Department develop strategies that will bridge the oral and written culture to ensure the actual dissemination of information ensuring real outcomes rather than a paper accountability of dissemination of information.

Agreed. KRS has a number of strategies in place to ensure that both written and oral messages or material compliment each other. This includes from a written perspective; formal policies and procedures, which when distributed are required to be read and signed off; and the provision of a handy index guide for all policies and procedures.

In addition to this formal written communication, all staff receive supervision from a deputy unit manager or unit manager. Management staff are available to assist direct care staff to understand policies and procedures and the requirements of the job. Unit meetings have been revamped to ensure policy and procedures, ie Policy of the Month, are discussed at all unit meetings, as are clients' IPPs.

KRS is aware of the need to ensure that communication occurs in a number of ways and a number of levels in order to best convey the messages that it wishes to provide to its staff. KRS will continue to review the way communication occurs.

Disability Services is developing a range of products aimed at promoting best practice in relation to fire safety information. A key element of this is the production of standard Fire Safety Manuals, one focusing on training centres and one focusing on the community based sector. These Manuals will contain all relevant standard or statewide information in addition to region/training centre/house/unit specific practices and procedures. Copies of the Manuals will be issued to all houses and units. All staff will be required to sign that they have read and understood the contents of the Manuals.

All houses/units will be required to prominently display the Metropolitan Fire Brigade approved standard Fire Orders and the house or unit floor plan. All staff will be required to familiarise themselves with the location and content of these items.

The video produced as part of the self-paced training package in community based accommodation services provides valuable assistance in promoting consistent practice in relation to fire safety issues. It is particularly useful for staff from Non-English Speaking Backgrounds.

Regions and training centres will be required to establish Fire Safety Committees which will, as part of their brief, have a role in promoting fire safety awareness at a local level and addressing any shortcomings identified. Regions/training centres will be required to hold regular house/unit meetings in which fire safety will be a fixed agenda item. These meetings will also incorporate a "Policy of the Month" system, where a chosen policy is subject to detailed discussion and consideration to in terms of highlighting staff awareness of key issues.

9.5 PHYSICAL ENVIRONMENT.

9.5.1 People who have an intellectual disability, particularly those living at KRS, should, in order to minimise risk and ensure safety, live in accommodation which is consistent with Principles of the IDPS Act.

Agreed. The Department of Human Services is committed to providing accommodation to clients within the principles of the Intellectually Disabled Persons' Services Act 1986.

9.5.2 The site at KRS be renovated to ensure that the risk minimisation features noted above obtain, to the greatest extent possible, for those residents who remain there.

Agreed in part. The Department of Human Services recently engaged BSA to undertake a review of all Training Centres including Kew, to identify the actions that need to occur in order to ensure all safety requirements are met. This is a high priority project which will be completed in the next few months. KRS will actively be involved with BSA in both the undertaking of the project and in follow up actions.

9.6 HUMAN RESOURCE ISSUES

9.6.1 The Department appoint a person in head office who is responsible for fire safety in residential services for people who have an intellectual disability.

Agreed in part. In Disability Services, all activities relating to fire safety are managed by a discrete team. The activities of this team include development of policy, practice instructions for staff and training materials. A range of materials have already been developed and are in use across all residential facilities, while a Practice Instruction relating to evacuation, for use in both community based accommodation and training centres, is currently being revised in consultation with MFB.

In terms of equipment and facility matters, expert advice is provided to Disability Services by Capital Management Branch as part of an overall approach to fire safety. As noted in response to recommendation 35 by the Parents' Association, the Fire Risk Management Strategy Committee will be formed with representation from each Division to overview the implementation of the Fire Risk Management Strategy implemented by the Department.

9.6.2 The manager on location of any residential service for people who have an intellectual disability be made responsible for the fire safety system to place.

Agreed. This is a standard practice across all facilities.

C. WORMALD FIRE SYSTEMS' SUBMISSION

The State of Victoria makes the following submissions with respect to the Recommendations for Changes to the Fire Detection and Protection System Installed at KRS made on behalf of Wormald Fire Systems in section 4 of their submission (page 32).

4.1 The practice of two contractors working on the same fire detection and protection system (by way of alteration, or service and maintenance) is prone to confusion and highly irregular in the fire protection industry. Wormald strongly recommends that it should cease.

It is agreed the practice should cease. Currently Wormald is responsible for the maintenance of the fire protection system in all residential areas of KRS. Jonkar Industries Pty Ltd is responsible for maintenance of the old fire protection system in non-residential areas of KRS. As outlined in the Fire Safety Improvements section of this submission, Section 2J, a new maintenance contract is being developed for the fire protection system at KRS, which will be monitored by consultants for the Department.

4.2 If recommendation 4.1 is rejected and the system of using two contractors is to continue, there should be a system whereby the work done by each contractor is fully documented and provided to the other contractor immediately and there should be monthly meetings between KRS and the two contractors to exchange information about the operation and updating of the system.

Agreed. Monthly meetings are held between KRS and each of Wormalds and Jonkar Industries. There is a clear protocol in place which delineates the responsibilities of these two companies.

4.3 The programming of the loop system at KRS should be altered from the present system which is dependent on the loop on which the building is located. Buildings contiguous to the building where the alarm has gone off should register that alarm on their mimic panels and by the activation of their lights and hooters.

As noted in response to recommendation 5 by the Kew Parents' Association, the consultant appointed to undertake the review of the fire protection system at KRS will be asked to examine this matter.

4.4 The mimic panels in the buildings at KRS are not capable of identifying the detector that has gone into alarm. They presently identify a zone number which can then be located by reference to a map (eg zone 2021 might be Flat B in Building 37). The programming on the mimic panels should be altered so that the display shows the Flat number rather than the zone number.

Disagree. The consultant appointed to undertake the review of the fire protection system at KRS will be asked to examine this matter. See also OPA recommendation (f) in relation to Specific Safety Measures to be Introduced.

4.5 To allow identification of the particular detector that has gone into alarm from every building, it would be necessary to replace the mimic panels with FIPs in each building and to program them into the system. If this were done, all the FIPs (ie the main FIP and all the building FIPs) would have text identifying the room in alarm. This would be an improvement on the existing information on the main FIP which can only show the number of the detector in alarm. To identify the room in alarm currently requires reference to the map folder at the main FIP. The cost of this would be substantial. The FIPs cost $3000 per unit plus the cost of installation and programming.

Disagree. See above response to recommendation 4.4.

4.6 All staff at KRS who may have to use the main FIP should be fully trained in its operation and there should be regular refresher courses to ensure this proficiency is maintained. In particular, staff at the administration building must be fully conversant with the procedure for identifying the detector and room which is in alarm. The staff member pushes the alarm acknowledgment button once to acknowledge the alarm. He or she then pushes the "point" button a second time to show the number of the detector in alarm and then identifies the room location by reference to the map at the main FIP. This information should be given to staff in the building in alarm to speed evacuation from the affected area and to the MFB while in transit to allow it to proceed directly to the room in alarm.

Agreed. All staff who use the main FIP are appropriately trained in its use. As noted in response to Villamanta Legal Service's recommendation 9.2.2 training on the Fire Safety System including use of the fire panel has been provided to 106 staff. Regular "Fire Panel" training will continue to be scheduled. As part of the management audit role of AHCOT, Unit staff are asked questions relating to their knowledge of the fire panel as part of regular audits carried out by AHCOT.

4.7 At present, the only place from which it is possible to identify the detector and room in alarm is from the main Fire Indicator Panel. It would be possible to have a pager system with the present equipment which would allow the zone in alarm to be identified (and if the zones were re-programmed to show flats, the Flat in alarm). If the mimic panels were replaced by FIPs, the pager would then also be able to identify the detector in alarm. Until some such solution is in place, there should always be a staff member on duty at the main administration building who can obtain information about the detector in alarm immediately from the main FIP. This is particularly relevant to the after hours situation where only two members of staff are at the administration building.

Disagree in part. KRS will request the Consultant reviewing the fire protection system to advise on how the night communication system can be enhanced to ensure maximum information is relayed via phone or pager to the AHCOT staff and to Unit staff via the Panel.

4.8 The possibility of pagers which would allow night staff to identify the Flat in alarm or the detector and room in alarm from locations away from the main FIP - as outlined in 4.6 - should be investigated.

Disagree in part. See response to recommendation 4.7 above.

4.9 Automatic door release mechanisms should be installed. These could be activated by the alarm system or, if this was prone to abuse, but a secure manual release point on the outside of the building in alarm.

As noted in response to the Kew Parents' Association recommendations 21 and 23, the consultant appointed to review the fire protection system at KRS has been asked to examine this issue.

4.10 The buildings should be fully sprinklered. This would avoid the danger of fire developing in the unsprinklered area of the building to a point where it cut off fire escape doors and/or overwhelmed the sprinklers in sprinklered areas.

Disagree. As noted in previous responses, this matter will be considered by the consultant appointed to review the fire protection system at KRS.

4.11 KRS should ensure that every maintenance contractor which carries out works on the fire protection system at KRS can demonstrate that it has a proper quality assurance system such as that stated in the International Standard ISO 9001:1994.

Agreed in part. The brief to develop new maintenance guidelines for DHS training centres outlined in section 2J of the Fire Safety Improvements section of this submission requires the determination of appropriate quality control/assurance systems for maintenance of all fire safety and security systems including requirements for independent checking and verification.

4.12 It should be a term of every contract relating to maintenance and installation works on the fire system at KRS that the contractor has obtained certification from an authorised body, such as the Joint Accreditation Society of Australia and New Zealand, and has in place a suitable quality assurance system such as that stated in ISO 9001:1994.

See response to 4.11 above.

4.13 To assist in the process of selecting suitable contractors, KRS should also develop its own management system which complies with ISO 9001:1994 and identify a list of preferred contractors which are certified as having in place a suitable quality assurance system such as that stated in paragraph 4.12 above. In developing that list of preferred contractors, KRS should also consider whether the contractor is a member of the Fire Protection Authority of Australia and therefore has access to current information relating to the fire protection industry in Australia, and give preference to such members.

Agreed in part. The brief to consultants outlined in section 2J of the Fire Safety Improvements section of this submission requires the consultant to develop specifications which ensure that all works are to be undertaken only by accredited installers and suppliers. It is recommended that any person working on the system must hold the appropriate certificate of accreditation from the Australian Fire Safety Practitioners Board Inc or equivalent.

D. UMOW LAI AND ASSOCIATES PTY LTD SUBMISSION

The State of Victoria makes the following submissions with respect to the recommendations on behalf of Umow Lai and Associates Pty Ltd in section 5 of the submission (page 39).

1 Clause 19 of the Building (Further Amendment) Bill 1997 which extends the operation of the building permit, occupancy permit and building inspection system to Government controlled buildings be strongly endorsed;

Agreed. This will be proclaimed on 1 August 1997.

2 Clause 19 be proclaimed to commence immediately;

As above.

3 A training, education, information and cultural change program should be instituted as soon as possible to widely inform and advise facilities and building managers and Government officers generally that private sector standards now mandatory apply to all Government buildings;

Agreed in part. The implementation of the amendments will be accompanied by information provided to all government departments advising them of their obligations under the amended Act. The binding of the Crown, in relation to obtaining building permits, will provide that facilities and building managers are part of the permit process. This ensures continuing professional development and ongoing education via the BCC information service (News bulletins, Practice Notes and Ministers Guidelines are regularly issued to all registered building practitioners). It is not possible to obtain a building permit under the Act without the relevant building surveyor checking that all involved persons are registered.

4 All Government buildings should be subjected compulsorily to a fire safety audit within a specified time frame. In this regard, the efforts of the Office of Building are strongly supported;

Disagree in part. All government departments are required to provide a report to Parliament under the Minister for Finance's Guideline 5 of 1994 by the year 2000. As the Crown will be bound on 1 August 1997 under the Building Act it is logical that all buildings within a municipality will be subject to the existing

review and inspection procedures available to municipal building surveyors. Government buildings would then be subject to the same requirements as existing private sector buildings.

5 **A program of mandatory ongoing inspections of Government buildings by qualified and experienced fire engineers and surveyors should be instituted;**

As for recommendation 4.

6 **The highest priority and urgency should be given by Treasury to the implementation of fire safety upgrade recommendations arising from fire safety audits;**

Due to time constraints the State of Victoria is unable to respond to this recommendation.

7 **A systematic program should be instituted to upgrade all Government buildings so that they comply with the Building Code of Australia;**

Disagree in part. Steps are already being taken to assess government buildings against the BCA. Government buildings should be subject to the same requirements as privately owned buildings. Existing buildings do not have to comply with the current technical regulations (BCA) except in certain circumstances detailed in regulations 3.3, 5.7 & 9.9 of the Building Regulations 1994.

8 **A streamlined approval and funding process should be adopted to fast track "Immediate" or "Urgent" projects desirably by Ministerial initiative to ensure the prompt and effective fire safety upgrade of Government buildings;**

Due to time constraints the State of Victoria is unable to respond to this recommendation.

9 **Senior management should be held accountable and must take responsibility for the preparation and implementation of facilities master plans and for the fire safety condition and fire safety upgrade priority given to Government buildings;**

Due to time constraints the State of Victoria is unable to respond to this recommendation.

10 **The Office of Building (or Departments and authorities as appropriate) should be required to raise and maintain a computerised fire safety compliance register listing in relation to all Government buildings relevant building details, including classification, salient history, fire safety audit details, and outstanding non-compliances, requirements and works;**

Agreed. The State of Victoria endorses this recommendation provided that such a measure supports an overall strategy and the information is used. A similar reporting requirement exists under Ministerial Guideline 5 of 1994.

11 **All necessary regulatory changes should be implemented to achieve the above recommendations.**

Due to time constraints the State of Victoria is unable to respond to this recommendation.

BUILDING PERMITS APPLICATIONS AND PROCEDURES

1 **Training should be conducted as to the implications for Government building managers as to the implications for them of the Building (Further Amendment) Bill 1997. In particular, in seeking building permits for Government buildings, it will now be necessary (as with private building work) to make application for building permits in the prescribed form; to provide building practitioners in writing with all prescribed or necessary information and to be responsive to their requests for information including for example.**

- **class of building**
- **past use of building**
- **proposed use of building**
- **number of persons likely to occupy building**
- **extent of works proposed**
- **fire safety measures proposed**
- **a plan clearly showing the layout dimensions of any existing building and the extent of proposed works**
- **details of all building works over the past 3 years.**

Agreed in part. As noted in response to recommendation 1 of the previous section, the implementation of the amendments will be accompanied by information provided to all government departments advising them of their obligations under the amended Act. The BCC has also already advised private and municipal building surveyors of the proposed requirements for Government buildings to be subject to a building permit. This will help to ensure that work will not be undertaken without a permit.

2 Occupancy permits will now become mandatory as will the conduct of inspections.

Agreed. All new building work will require a building permit and, where applicable, an occupancy permit.

3 It should be made mandatory for building practitioners when considering building permit applications to:

- **inspect the file held by the relevant local municipality relating to any existing building as to which approval is sought;**
- **ensure that details of all applications and approvals are provided to the relevant municipality for its building files;**
- **physically inspect any existing building as to which application is made;**
- **personally inspect all buildings for which approval has been granted or confirm that another qualified building practitioner has completed interim and final inspections.**

Agreed in part. Bullet point 2 and 4 are already required by the Building Act (refer sections 30 and 73). Bullet points 1 and 3 represent good professional practice. This could be further highlighted in a Practice Note or Ministers Guideline if necessary. However, it is noted that there may be difficulties practicably fulfilling such requirements.

MAINTENANCE

1 An accreditation scheme for Government building fire system maintenance contractors should be introduced;

Agreed in part. This is a matter for consideration by individual government Departments. As outlined in response to Wormalds recommendations 4.11 to 4.13, the Department of Human Services is in the process of developing specifications to ensure that all works are to be undertaken only by accredited installers and suppliers.

2 Government building fire system maintenance contracts should be awarded only to accredited maintenance contractors;

See above response to recommendation .1.

.3 Maintenance contractors will remain accredited only if they operate a quality assurance system with proper record keeping and work procedures;

As above.

4 Accredited maintenance contractors are required at all times to adhere to Australian standard AS 1850, and will be subjected to periodic quality audits by the accreditation authority.

As above.

FIRE AUDIT STANDARDS OR GUIDELINES

1 In the absence of any Australian Standard or code of practice governing the scope and methodology of the various types of fire audits, the Fire Code Reform Centre (or Standards Australia) be requested to develop an Australian Standard or code of practice for the conduct of the various types of fire audits.

Disagree. Standards Australia has a Standards Committee considering Fire Safety Engineering at present (BD/18/20)

2 The Metropolitan Fire Brigade or the national organisation of which the MFB is a member be represented and provide input to the Fire Code Reform Centre in the development of an Australian standard or code of practice for the conduct of fire audits.

Agreed.

E. SUBMISSION ON BEHALF OF THE OFFICE OF THE PUBLIC ADVOCATE

The State of Victoria makes the following submissions with respect to the Recommendations proposed by the Office of the Public Advocate in section 4 of their submission (page 4).

GUIDELINES FOR SAFE HOUSING OF PEOPLE WITH DISABILITIES

Current and future residences for people with intellectual disabilities should be guided by the following safety guidelines:

(a) In recognition of the increased risk of fire and associated life-endangering phenomena posed by the characteristics of large congregate care residences, people with intellectual disabilities should be housed in units of a size comparable to domestic residences in the general community.

It is agreed that wherever possible, people with intellectual disabilities should live in the general community. In the past institutions for people with a mental impairment (whether a mental illness or an intellectual disability) were based on hospital models. The adoption of such a model automatically led to large congregate care settings where services to people with an intellectual disability were provided by staff trained in medical or allied health areas.

In the early 1980's significant policy changes occurred in relation to the provision of services and care to people with an intellectual disability. The Government introduced the Community Residential Unit supported accommodation program, which offered people with an intellectual disability the option of residing in the community. Since this time successive governments have been committed to providing accommodation for people with intellectual disabilities in a community setting, rather than in an institutional environment. This policy recognises that people with an intellectual disability should, wherever possible, be given the opportunity to live a lifestyle which is similar to that experienced by the rest of the community.

The Government also recognises that Victorian and overseas experience demonstrates that where people with an intellectual disability move from institutions into the community their general well being and opportunities improve significantly. The Human Resource Centre at Latrobe University has recently published two significant studies into the relocation of clients from large institutions to the community (Evaluation of the Relocation of the Aradale and Mayday Hills Clients Project; Evaluation of the Relocation of Caloola Clients Project: A Three Year Follow-up of Former Caloola Training Centre Clients) These studies found that there was a significant improvement in the quality of life for residents who moved from institutional settings to the community.

In the early 1980's there were 13 institutions providing accommodation and support for over 3000 people. By the middle of 1997 there will be four residential institutions in Victoria with another to close by 2000. Likewise since assuming administrative responsibility for a number of non-government "hostels" from the Commonwealth, as part of the Commonwealth/State Disability Agreement, the Victorian Government has worked with many of these agencies to move over 170 people from these services into the community.

Successive Victorian Governments have adopted the reduction in the number of people living in institutions as one of the priorities for disability services. The other key priority has been to provide additional accommodation support for people who are on the waiting list for services. Since the 1980's Governments in Victoria have attempted to balance these priorities while also improving standards in the remaining residential and community based residential facilities. The movement of clients to the community and the upgrading of existing larger scale facilities is a priority of Government and will continue as resources permit.

(b) Residences should be designed in recognition of the fact that the fewer residents, in general the safer the residence is for those residents.

Agreed. As noted in the response to recommendation (a), it is acknowledged that smaller residences are preferable for a range of reasons.

(c) Maximum opportunity should be afforded to residents to optimise their own safety and to learn protective behaviours.

Agreed. Programs such as individual program plans and developmental programs, provide a framework in which clients are provided with maximum opportunity to develop general life skills and to learn protective behaviours, where a need for these has been identified.

(d) Care for the residents should be provided so as to maximise the independence, autonomy and flexibility of residents so as to equip them to respond safely in relation to safety issues and particularly in the context of an emergency.

Agreed. In line with the *Intellectually Disabled Persons' Services Act* 1986, the principle of least restrictive alternative is applied to the provision of support and the implementation of individual program plans. While every effort is made to maximise clients' independence, autonomy and flexibility, this must be balanced against the Department's duty of care to its clients. In recognition of the Department's duty of care, client safety and well-being must be paramount.

Clients who have the capacity to do so learn the procedures to follow in emergency situations through their participation in regular evacuation drills. In addition, staff are required to assess if clients have the ability to communicate that they, or others, are in danger. Where communication difficulties are experienced, staff must ensure that appropriate strategies are put in place so that clients can respond to emergencies in the most effective way possible.

(e) Sufficient, individually tailored training should be provided to staff to enable them to maximise the independence, autonomy and flexibility of residents in respect of general life skills, which would equip them to respond safely in relation to safety issues and particularly in the context of an emergency.

Agreed. The Department, in consultation with the Metropolitan Fire Brigade, introduced a comprehensive training strategy in which specifically tailored training will be provided to all staff in both training centre and community based accommodation settings. This strategy will ensure that all staff receive the relevant level of training which will continue to be reinforced through appropriate refresher courses. A major focus of the training strategy is on addressing clients needs in emergency situations such as lifting techniques and clients management techniques. Action taken by staff to ensure clients' safety and well-being will, in emergency situations, take precedence over clients' rights to exercise independence, autonomy and flexibility.

(f) Sufficient information should be formally recorded by carers in relation to any particular dangers posed by residents so that such matters can be responded to promptly, appropriately and safely.

Agreed. The Disability Client Information System, DISCIS, is currently being implemented statewide and is a database for recording individualised client information. A client profile can be printed for each client which includes information about whether the client has alerts which should be noted and specifies the general type of alert. Alerts may include fire risk or fire lighting behaviour, challenging behaviour including self-injurious, injury to others, dangerous sexual behaviour and property damage. There is also the capacity within the 'Alerts' section to identify individualised management strategies to address the identified behaviour. Further client information available on the DISCIS system includes identification of specific health and behaviour issues. The case note function on DISCIS will be able to be used as an on-going record within training centres units. This will enable staff to complete daily case notes on the DISCIS system as well as record 'day-night' reports.

As staff in community based accommodation services do not yet have access to DISCIS, they will continue to use a paper-based record in the form of the Accommodation Service file which contains a print-out of the DISCIS client profile and notes on any special precautions related to health and/or behaviour. It also has sections for recording on-going case notes and client management and support information.

(g) Sufficient pertinent information about the current needs of particular residents and any safety issues arising out of recent incidents or behaviours should be provided during "handover" times between carers' shifts.

Agreed. As noted in the section 21 of the Fire Safety Improvements section of this submission, the Disability Services Practice Instruction states that at the commencement of their shift incoming staff must check all clients and read recent entries in the communication book or the relevant shift for further information on night routines and individual client needs.

(h) Safety measures should be developed in conjunction with the Metropolitan Fire Brigade for individual residences in such a way as to maximise the independence, autonomy and flexibility of residents.

Agreed. As noted in the Fire Safety Improvements section of this submission, all residences will be required to undertake evacuation drills. These drills will be developed specifically for each residence, which will include a consideration of the particular needs of those people who reside in the house or unit. The focus of the Disability Services Division's response to fire risk behaviour is on individual behaviour and response for each intellectually disabled person who receives services from the Department.

(i) Safety programmes should be developed in a way which is adapted to the particular behaviours, histories and disabilities of residents.

Agreed. Departmental Instructions as to the frequency of fire evacuation drills will be issued. In recognition of the numbers and evacuation capacity of clients, each training centre unit will be required to undertake six drills per annum while community based accommodation services will be required to undertake four drills per annum. The drills will be conducted at various times during the day with a certain number to be conducted at night. The Instructions will also provide details of the observation required, the records to be maintained and process for undertaking follow up action. These procedures will enable house/unit staff and management to tailor evacuation plans to particular house/unit and client requirements.

(j) Safety programmes should be developed in such a way as to minimise the potential for miscommunication and human error arising out of unnecessary complexity and inaction arising out of ambiguous allocation of responsibility.

Agreed. Disability Services has revised its evacuation procedures in consultation with the Metropolitan Fire Brigade. Practice Instructions will be issued which state that staff must follow the Metropolitan Fire Brigade's simple, easy to follow Fire Orders. Specific Fire Orders have been developed for both community based accommodation services and training centres. The Fire Orders must be prominently displayed in office/staff areas and, where appropriate, near exit doors.

(k) The structure of residences should optimise the degree of ingress and egress practicable for residents, particularly in circumstances of emergency, such as the need for urgent evacuation, taking into account the fact that residents are both voluntary occupants and persons in need of care.

Agreed. Community based houses operated by the Department of Human Services are designed to comply with building regulations and the Departmental standards for fire safety in supported community based houses. New houses are planned around the requirements of the intended resident group with particular emphasis on ingress and egress components. Existing houses are modified, as required, whenever a new resident requires modified facilities in the house and/or ingress and egress components.

In Training Centres the design of ingress and egress components are modified, as required, dependent on the intended resident group for a particular unit.

The basic principle underpinning ingress and egress is that houses/units are considered as clients' homes. The Department's policy is that units/houses must not be locked unless clients are at risk of harming themselves or others. If doors must be locked, they must be capable of being readily opened in case of emergency.

(l) The size of a residence should be proportionate to the number of residents living within it because of the safety risks of large or inappropriately designed residences.

Agreed. Community based houses operated by the Department of Human Services are designed to comply with building regulations and the Departmental standards for fire safety in supported community based houses. The Department is of the opinion that the size of its houses is proportionate to the number of residents living in them.

In Training Centres a number of units seen as inappropriate for resident occupation have been closed, and some demolished. This is part of an ongoing policy of the Department to close inappropriate units or modify and redevelop those units that can suitably be redesigned to more adequately accommodate resident groups.

(m) Residences should be designed so as to enable proximity of carers to residents, consistent with the potential needs of residents in circumstances of emergency, and consistent with the residents' entitlement to privacy.

Agreed. Community based houses operated by the Department of Human Services are designed to ensure that carers are in close proximity to residents. At least two living areas are provided in each house. When new housing is planned, individual bedrooms are provided for each resident, if required, consistent with a resident's entitlement to privacy. In houses purchased prior to the implementation of policy to provide individual bedrooms, the Department provides individual bedrooms for each resident wherever possible. Fire safety drills have been included in the emergency procedures for the community based houses.

In community based houses where staff are on sleepover rosters, the staff bedrooms are placed so they are close to residents' bedrooms.

In Training Centres individual bedroom areas are provided wherever possible consistent with a resident's entitlement to privacy. Separate living areas are provided. Disability Services has revised its evacuation procedures in consultation with the MFB that are consistent with the potential needs of residents in circumstances of emergency. Active night staff are available at all times in all units.

(n) Sufficient staff should be rostered both during the day and at night, to respond adequately to individual residents in face of a threat to safety or an emergency

Agreed. Staffing levels in all the Department's facilities take into account a number of factors, including response in the case of emergency. Sufficient staff are rostered to respond to client safety and care requirements.

(o) Staff should be trained sufficiently to respond to residents in circumstances of emergency.

Agreed. As noted in Section 4 of the Fire Safety Improvements section of this submission, to support the new Disability Services Policy Statement, and associated policies the DSTU have included specific information on fire risk behaviours in training courses for BIST workers and in the orientation training for residential workers. Senior staff will be required to undertake fire warden training this year.

(p) Hard copy resident profiles, accompanied by a reasonably recent photograph, together with relevant alerts, should be made easily accessible and read as a matter of standard procedure by any carers dealing with residents.

Agreed. As noted in section 12 of the Fire Safety Improvements section of this submission, all training centres and CRUs will be required to maintain up to date client master lists which include a client identification card which contains a client photograph and details. As noted in response to recommendation 51 made by the Kew Parents' Association, it is agreed that this should be mandatory reading for all carers.

(q) Efforts should be made to optimise the continuity of care of residents, in recognition of the fact that carers accustomed to working with residents well-known to them are more likely to be attuned to developing circumstances of risk and danger.

Agreed. As noted in response to recommendation 31 made by the Kew Parents' Association, KRS has implemented a number of strategies in this respect.

Throughout Disability Services Accommodation Services every effort is made to ensure a consistency of staff who have familiarity with the residents. In the interests of good employment practice, meeting staff development needs and ensuring a broadly skilled workforce, there will always be some rotation of staff. Complete continuity cannot be guaranteed due to staff absence and turnover, however, in providing replacement staff, every effort is made to ensure staff are familiar with the clients they are caring for.

(r) Evacuation protocols should be designed for each residence in a way that is tailored to the needs and level of disability of residents.

Agreed. As noted in response to recommendation (h), evacuation protocols will be designed for each residence. This will necessarily take into account the needs of the residents of each house/unit.

(s) Safety programs, including evacuation protocols, for residences should be designed in consultation with residents, carers, management, the Metropolitan Fire Brigade and other relevant agencies.

Agreed. As noted in Section 9 of the Fire Safety Improvements section of this submission, all training centres will set up a liaison structure with the local MFB or CFA which will facilitate orientation visits, formal feedback on evacuation drills and improvements which can be made in existing systems. The Manager, Client Services will establish an appropriate structure for Community Residential Services programs to ensure such liaison occurs.

(t) Evacuation procedures should be practised at regular intervals, both at times during the day and at night, so that both staff and residents optimise the capacity of staff and residents to evacuate a residence in circumstances of emergency.

Agreed. As noted in section 10 of the Fire Safety Improvements section of this submission, all training centres will be required to undertake six fire drills per unit per annum. CRUs will be required to undertake 4 drills per annum. The number of drills which are observed by the local MFB/CFA will be determined at a local level between management and the MFB/CFA. All drills will be required to be evaluated and a follow up sheet produced detailing action required for improvements. The systems established at KRS for scheduling, evaluation and follow up of drills will be utilised as a best practice model for all other Disability Services' institutions and houses.

(u) Staff should receive regular (at least six monthly) training in emergency procedures and the use of first response fire equipment.

Agreed in part. As noted in section 11 of the Improvements document, to support the new initiatives around fire safety training for all staff a policy with respect to requirements for refresher training is being developed.

SPECIFIC SAFETY MEASURES TO BE INTRODUCED

The safety of current and future residences for people with intellectual disabilities should be supported by the following specific features:

(a) There should be hard-wired addressable smoke detectors in all rooms of all residences to maximise the early detection of fires.

Agreed in part. The Department of Human Services supports the use of hard wired addressable smoke detectors in residences which have greater than six permanent occupants. These detectors must be installed in every bedroom, in exit routes, hallways and living areas. For residential houses in the community the appropriate standard required is domestic smoke detectors in compliance with AS 3786. All Disability Services community residences have interconnected smoke detectors connected to mains power with battery backups.

(b) There should be residence-based alarms for all residences triggered by smoke detector activation to enable early warning to residents and staff of fires.

Agreed. Consistent with the policy outlined in response to recommendation (a) above, the Departmental requirement for audible alarms is that smoke detector triggered alarms must achieve a sound level of at least 75dBA at pillow level, but not more than 95dBA at head height in any position in the building.

(c) There should be full sprinklering for all residences, where rapid evacuation is not possible, to maximise the potential for early extinguishment of fires.

Agreed in part. The new Departmental Guidelines for community based houses will require sprinklers to be installed if the evacuation time for the house exceeds that of a normal family, ie. more than three minutes. Congregate care facilities will be required to be sprinklered under the proposed new Building Regulations to be introduced in August 1997. All Disability Training Centres are installed with automatic sprinklers.

(d) Fuel loads should be kept to levels consistent with safety.

Agreed. The fuel loads within individual units or houses are managed at a local level. However, the Department notes that the most significant contributory to fuel loads is clients' personal effects. In determining fuel loads due consideration must also be given to clients' quality of life.

(e) There should be an AIU facility to the Metropolitan Fire Brigade in all residences.

Disagree. While all training centres have alarms linked to local MFB/CFA it is not practical to directly link all fire protection systems in community based houses in such a way. The number of connections required, and the level of false alarms due to domestic cooking in kitchens would mean that such a system would not be feasible. As noted in response to recommendation (a) in this section the appropriate standard required in such houses is domestic smoke detectors in compliance with AS 3786.

(f) There should be mimic panels in each residence to enable staff to ascertain speedily the location of activated smoke detectors.

Disagree. The Department does not support this recommendation. Mimic panels are not the only means by which the location of a detector can be determined. Other options include pager systems, indicator panels or small lights outside buildings. As noted elsewhere, the Department will undertake a fire safety audit of all buildings. It is expected that consultants undertaking the audits will consider what measures are necessary, and report accordingly.

(g) A master key system should exist in all residences for windows and doors.

Agreed in part. A master key system is in place at KRS, but does not include the windows, as this is not a feasible option.

Fire safety audits were conducted on all Disability community residential units in March/April 1997 to assess compliance with the Department's Guideline for Fire Detection and Alarm Services in Domestic Accommodation (Class 1B). This guideline includes a requirement for master key locking systems. Following the audits, Regions were instructed (15 May 1997) to immediately undertake works where the audits found that houses did not comply with the guidelines.

(h) Automatic door strikes, operated by instigation of smoke detectors, should operate in all residences to enable speedy evacuation in circumstances of emergency.

Agreed in part. Door strikes have been fitted in all training centres as the result of specific recommendations by fire safety engineers, with the exception of KRS. Although this has not been previously recommended at KRS the issue will be considered by the consultant undertaking the review of the fire protection system.

The recently approved, Capital Development Guideline - May 1997, Technical Guidelines, Fire Risk Management, Guideline for Fire Risk Management in Supported Community Based Houses (which replaced the Department's Draft - Guideline for Fire Detection and Alarm Services in Domestic Accommodation (Class 1B)) does not require installation of this type of door strike. The only exception to this will be where the house must be locked to reduce the risk of clients harming themselves or others.

(i) There should be adequate fire and smoke compartmentation within residences in accordance with the Building Code of Australia.

Agreed in part. Smoke and fire compartmentation is one of the passive fire protection systems which work to support the full time fire protection system installed in a building. Under the new performance based BCA, to be introduced in August 1997, a fire engineer will be required to determine the most appropriate single system for a particular site.

(j) Maps of the structure of residences should be prominently displayed within a prominent area of all residences, as recommended by the Metropolitan Fire Brigade.

Agreed. As noted in section 6 of the Fire Safety Improvements section of this submission, all training centres and community based accommodation will now be required to produce floor plans which comply with MFB standards. These floor plans will be required to be kept in both the house/unit and in an alternative location to provide a backup system if required.

(k) Maps of the structure of residences should be provided to the Metropolitan Fire Brigade.

Agreed. See response to recommendation (j) above.

MONITORING OF SAFETY

The safety of current and future residences for people with intellectual disabilities should be provided for on an ongoing basis in accordance with the following procedures:

(a) Sufficient auditing and monitoring processes, at regular intervals, should be employed to ensure that staffing levels are sufficient for residents' safety and that appropriate safety technologies have been installed in residences.

Agreed. As noted in section 2 of the Fire Safety Improvements section of this submission, the Department's Fire Risk Management Strategy will require all departmental facilities to undertake fire safety audits. As noted in section 2J of the Fire Safety Improvements section of this submission, a consultant is also currently preparing specifications for a maintenance contract for fire and security systems which will include regular auditing of the systems.

STAFFING LEVELS ARE CONSIDERED SUFFICIENT.

(b) Sufficient auditing and monitoring processes, at regular intervals, should be employed to ensure that the safety technologies installed in the residences continue to function at an acceptable level.

Agreed. As noted in section 2J of the Fire Safety Improvements section of this submission, the Department has appointed consultants to draw up a maintenance contract of fire protection systems for adoption by Disability Services' Training Centres. This will include regular audit and monitoring of such systems. This contract will be piloted at KRS and is expected to be in place by December 1997.

(c) Lines of responsibility for expeditious and sufficient upgrading of safety procedures and facilities at all residences housing people with intellectual disabilities should be clearly and simply specified.

Agreed. As noted in the Fire Safety Improvements section of this submission, the Departmental Fire Risk Management Strategy requires each region to have a central management point responsible for implementing the strategy and a regional steering group will be responsible for overseeing the implementation of audits and high and medium priority works.

IMPLEMENTATION

The following implementation processes should be constituted:

(a) A working group, consisting of representatives from the Department of Human Services, the Building Services Agency, Kew Residential Services, the Kew Parents' Association and the Office of the Public Advocate, should be established immediately to plan and implement the safe housing of people with intellectual disabilities in the care of the Department of Human Services.

Disagree. Ensuring the safety of housing for people with a disability is a matter dealt with through the Department's direct line management. This is done in the context of design and fire safety standards developed by the Department, with the assistance of consultant architects and fire safety engineers.

F. SUBMISSION ON BEHALF OF THE MFB

The State of Victoria makes the following submissions with respect to the Recommendations proposed by the MFB in section D of their submission (page 103).

1 **A system of smoke alarms must be installed in all residential care facilities. In the case of a class 3 and class 9a building the system must comply with AS 1670-1993 and in the case of a class 1 building the system must comply with AS 3786-1993. These recommendations are to be made retrospective with works being completed within an acceptable time frame, 5 years. Note 1: This may require the replacement of thermal detectors with smoke detectors/alarms. Note 2: The standard of alarm system required will be dependent on the coverage provided by a sprinkler system.**

Agreed in part. The Department has required class 1 buildings to contain smoke detectors since 1994. The Current draft guidelines for such houses exceed the Australian standards. Through the Department's Fire Risk Management Strategy the Department will have smoke detectors installed in all its buildings to the above standards in the next three years.

The State of Victoria also notes that Regulation 5.14 of the Building Regulations 1994 requires smoke alarms to be fitted to all existing Class 1,2,3 and 4 buildings by 1 February 1999.

2 **Where false alarming is occurring in a smoke detector system, systematic appropriate remedial action must be taken, and smoke detectors must not be inappropriately changed for thermal detectors as a solution.**

Agreed. The Department agrees that smoke detectors should not be replaced by thermal detectors unless a qualified fire engineer determines that this is appropriate.

3 **The current problems with the alarm system at KRS must be resolved as a matter of urgency. The system must be made fully addressable and identify room numbers, rather than zones; at the very least the system should be programmed to perform at the best of its capabilities. Maps showing the room numbers should be installed next to the mimic panels and the main alarm panel. Rooms should be marked with room numbers so as to familiarise staff with those numbers. The AHCOT team must receive notification on their pager of the location of the unit in alarm.**

Agreed in part, though the Department does not acknowledge problems with the alarm system at KRS. The consultant who has been appointed to undertake the review of the fire protection system at KRS will consider these matters and advise accordingly.

4 **The Department of Human Services must ensure that all relevant staff at KRS have a full and operational knowledge of the addressable mimic panels at units and the main panel at the administration centre.**

Agreed. As noted in response to Wormalds' recommendation 4.6 and Villamanta Legal Services' recommendation 9.2.2, all staff who use the main FIP are appropriately trained in its use. Training on the Fire Safety System including use of the fire panel has been provided to 106 staff. Regular "Fire Panel" training will continue to be scheduled. As part of the management audit role of AHCOT , Unit staff are asked questions relating to their knowledge of the fire panel as part of regular audits carried out by AHCOT.

5 **The Metropolitan Fire Brigade should continue with its aim to reduce response times to alarms of fire. The Brigade should be commended on the 1996/97 goal of achieving response times of 7.7 minutes in 90% of cases. It should be acknowledged that the Brigade's prompt response to the fire at Unit 30/31 saved lives.**

This is not a matter for DHS to comment on, though it commends the MFB for its prompt response to the fire on 8 April 1996.

6 **Residential institutions must have a sprinkler system that complies with the minimum requirements of AS2118.4 of 1995 installed in all compartments including roof spaces where fire separation is not provided for. Sprinklers must be installed at all residential care properties, regardless of their**

classification. This is particularly important following the move to integrate the mentally disabled into the community and move them directly into class 1b occupancies. It should be noted that buildings in this classification can still retain security mechanisms such as bars on windows, locked doors and polycarbonate glazed windows. These recommendations are to be made retrospective with works being completed within an acceptable time frame of 5 years. Fire separation of compartments excluded from sprinklers should only occur in accordance with section 2 : 10 AS 2118.4 of 1995.

Disagree in part. It is noted that all Departmental Training Centres have automatic sprinklers, and this matter will be reviewed at KRS by the consultant reviewing the fire protection system. Sprinklers are one component of the total fire protection system of a particular residence. The Department has developed guidelines for community based accommodation which requires sprinklers where evacuation times exceed those of a normal family. In such cases sprinklering will be required to AS2118.4

The State of Victoria notes that the BCC is addressing the issue appropriate classification of buildings where care is provided to people with disabilities. A practice note on this issue will be distributed to all registered building practitioners. Proposed Regulation 5.15 of the Building Regulations 1994 is intended to come into operation on 1 August 1997 and will require AS 2118.4-1995 sprinkler systems to be installed throughout all residential care buildings (as defined) within 5 years.

7 **If clients must be housed in locked premises then the doors must be fitted with automatic unlatching devices to provide ease of escape in a fire emergency.**

Disagree. As noted in response to OPA's submission on specific safety measures to be adopted item (h), all training centre units have been fitted with smoke activated automatic door strikes, with the exception of KRS where the issue will be considered by the consultant undertaking the review of the fire protection system. Community based houses will only have such doors fitted where the house must be locked to reduce the risk of clients harming themselves or others.

8 **If it is necessary for residential care facilities to be provided on a secure basis then it is critical that automatic sprinklers and a local alarm system be provided in such premises.**

Agreed in part. As noted in response to the OPA submission on specific safety measures recommendation (c) sprinklers will be required to be installed if the evacuation time for a community based house exceeds that of a normal family. Congregate care facilities will be required to be required to be sprinklered under the proposed new Building Regulations to be introduced in August 1997. All Disability Training Centres are installed with automatic sprinklers.

9 **The system of sprinklers to be installed in residential care facilities should be a complete - not partial - automatic sprinkler system. Where there is not complete sprinklering then there must be fire separation at compartments excluded from sprinklers in accordance with AS 2118.4 1995, Clause 2.10.**

Disagree in part. Where building regulations require sprinklers this will be introduced if buildings do not comply. Under the Department's Fire Risk Management Strategy recommendations of consultants undertaking audits as to full, partial or no sprinklering will be considered as part of the total fire protection system.

The State of Victoria notes that proposed Regulation 5.15 of the Building Regulations 1994 is intended to come into operation on 1 August 1997 and will require AS 2118.4-1995 sprinkler systems to be installed in all residential care buildings (as defined) within 5 years.

10 **All units at KRS where there is partial sprinklering must be upgraded to full sprinklering as soon as possible with Unit 7/8 receiving immediate priority.**

Disagree in part. As noted elsewhere, Unit 7/8 will be fully sprinklered as a matter of priority. The consultant appointed to undertake the review of the fire protection system at KRS will report on whether full sprinklering is appropriate.

11 **The Department of Human Services should set up a consultative task-force to review emergency and fire safety procedures at all Department residences and facilities.**

Agreed. The Department's fire risk management strategy outlined in section 2 of the Fire Safety Improvements section of this submission will establish procedures for all departmental residences and facilities which will include consultation at a local level with appropriate bodies such as the MFB/CFA.

12 **The generic emergency procedures must be reviewed and amended for each institution. The MFB should be represented on the taskforce to design generic emergency and fire safety procedures for Department residences.**

Agreed. The IDS Accommodation Services Emergencies Manual has been updated and the MFB has been consulted as part of this process. Each training centre will be required to develop site/client specific emergency procedures based on the generic material provided by relevant fire authorities (MFB/CFA). The MFB or CFA must be consulted in the development of these specific procedures.

All training centres are required to establish regular formal liaison with the MFB/CFA to ensure that issues of concern are adequately addressed.

The MFB will be consulted in the development of the standard Fire Safety Manual both in terms of its structure and minimum information requirements.

13 All staff must receive training in the emergency and fire safety procedures relative to their level in their institution or facility.

Agreed. See response to Kew Parents Association recommendation 38, Villamanta Legal Service recommendation 9.2.2 and OPA Guidelines for housing recommendation (o), and Fire Safety Improvements section of this submission section 11.

14 The Chief Fire Safety Warden at each residence or facility must maintain a training log.

Agreed in part. The Fire Safety Manual to be distributed to all residential services will contain a record of training undertaken by each member of staff. Responsibility for maintaining the record will rest with Unit Managers and House Supervisors. In training centres, the responsible officer will be required to maintain an oversight role in ensuring that the records are up-to-date and action taken for staff to attend any outstanding training.

15 All new staff or staff that are new to an institution or facility must undertake the training as a compulsory part of their induction program.

Disagree in part. As noted in the Fire Safety Improvements section of this submission, all staff at KRS are required to attend a one day orientation session before commencement and receive a unit orientation on their first shift. As noted in response to Recommendation 43 by the Parents Association, and recommendation 9.2.2 by Villamanta Legal Service all staff are required to undertake orientation training within six months of commencement of employment.

16 Every unit at Kew Residential Services must have a short booklet provided to all staff and available for all temporary staff to inform them of the basic procedures for that unit.

To be considered. Kew Residential Services has a Fire Safety Manual. As noted in the Fire Safety Improvements section of this submission, this new manual which was first introduced in June 1995, is a result of significant and ongoing consultation with the MFB. The manual has been reviewed and updated a number of occasions. Each time there is an update, this is sent to the MFB for comment and endorsement prior to the release. The MFB have commented positively on both content and layout of the Manual and the active approach to reviewing the manual.

As noted in the Fire Safety Improvements section of this submission section 13, each time an update to the manual occurs, Units are required to hand in the former version and all staff are required to sign off they have read the new edition. At the back of the manual there is a sign-off sheet, which indicates all staff have read and signed the manual.

The manual includes standard information for all units and, at a unit specific level, includes the floor plans of that unit.

During the regular consultation with the MFB Fire Safety Education Unit, the MFB/KRS Liaison Committee, the idea of a short booklet for each unit has never been raised. Notwithstanding this, KRS will discuss this proposal with the MFB to explore whether this would provide further enhancement to the existing documentation.

17 The Department of Human Services must ensure that all staff with low English language proficiency have adequate access to emergency procedures.

Agreed. KRS has taken an active approach to communicating with staff who have a lower English language proficiency. Over the last three years regular, accredited, courses through TAFE have been offered on site in literacy and numeracy. A number of staff have undertaken the courses and have significantly improved both their comprehension and their speaking of English. Furthermore KRS management has explicitly made it clear to Unit Managers and Deputy Unit Managers that, if they have concerns about a staff member's capacity

to understand written documentation, then they are to sit down with that staff member and talk them through the policies and procedures that have been released, including the Fire Safety Manual.

Furthermore staff who have attended Fire Safety Response Training, but who it is considered would benefit from repeating this training, have recently been scheduled to attend repeat training. This is to ensure that staff who may have some difficulty with understanding all of the material at the first session have an opportunity to repeat the training and learn further details about fire safety response. The Fire Safety Response Training which is conducted by the MFB is very interactive in its nature and includes practical demonstrations and exercises to enable participants to understand the information and the skills that are being presented by the trainer.

Throughout Disability Services essential information in relation to fire safety and emergency issues will be adequately communicated to all staff, including those with a Non-English Speaking Background, in a variety of ways.

- All staff in community based accommodation services must undertake the self-paced training package which includes video instruction in emergency procedures.
- The fire safety training will include experiential components which provide staff with experiences similar to a real fire situation.
- The conduct of regular evacuation drills will consolidate experience and supplement information received though other sources.
- The Standard Fire Orders to be displayed and followed in each residential setting are written in plain English and accompanied by diagrams.

18 The Department of Human Services must ensure that appropriate training time is allocated to fire safety training.

Agreed. As noted in the Fire Safety Improvements section of this submission in the DSTU offers a wide range of courses, a number of which include fire safety training. Between August and November this year, all House managers and Cluster supervisors will be required to undertake Fire Safety and Emergency Procedure Training. However, it should be noted that fire safety training is only one aspect of a broader range of training which the Department offers to its employees.

19 The "buddy system" mechanism at Kew Residential Services must be changed as a matter of urgency so that the nearest units respond to an alarm.

Disagree. The consultant appointed to review the fire protection system at KRS will be required to comment on any changes which may be necessary to the buddy system.

20 As part of the continuing upgrade of the fire safety system at KRS every unit at Kew Residential Services must have a primary and secondary evacuation point, marked by a beacon.

Agreed. As noted in the Fire Safety Improvements section of this submission, section 10, all Units at KRS have a primary and secondary evacuation point. All evacuation packs contain a portable beacon to indicate the evacuation point.

21 Each unit at Kew Residential Services must have an Emergency Information Locker. The MFB should assist the Department of Human Services in designing and manufacturing Emergency Information Lockers for Kew Residential Services and similar institutions.

Agreed in part. An emergency information locker will be installed in each unit. Provision has been made for this project from the minor works budget. Similarly to recommendation 16, the idea of an Emergency locker for each unit has not been raised by the MFB Education Unit, nor at the MFB/KRS Liaison Committee. Notwithstanding this, it was the suggestion of Inspector Martin during the course of the Inquest.

Francene McCartin, Manager, KRS will be arranging to discuss how the lockers could work with the MFB in the near future. The difficulty which can be envisaged with such a proposal is that the lockers would need to have the information contained in them updated every night of the week due to the movement of clients. KRS is keen to pursue any positive suggestion that the MFB make and will make arrangements to discuss the proposal in detail.

22 All doors at Kew Residential Services and similar institutions should be keyed with a single key.

Agreed. KRS has moved to a single master key system. As noted in response to OPA's recommendation (g) in Specific Safety Measures to be Adopted, all Government run residential institutions have had master keying systems installed.

23 The Department of Human Services must set up a task force to approach the issue of appropriate staff-client ratios and to report within twelve months.

Disagree. As noted in response to recommendations 25 and 29 of the Parents Association submission and Recommendation 1.1 of the HACSU submission, staffing levels in all the Department's facilities take into account a number of factors, including response in the case of emergency. Sufficient staff are rostered to respond to client safety and care requirements.

24 Any changes in the staff or client make-up of a unit at Kew Residential Service must be advised to the Chief Fire Safety Warden for the consideration of the fire safety implications of such a change.

Disagree. Following any changes in the staff/client make up of the unit, KRS undertake to review the fire safety response procedures for that unit to ensure that they take into account these changes. Furthermore, if required, KRS will consult the MFB on the implications of change and seek advice as appropriate.

25 The categorisation of the behaviour of a client in a particular category should not be allowed to obscure the true nature and degree of the fire risk presented by that behaviour.

Agreed. The Disability Services Policy Statement and the strategies outlined in section 3 of the Fire Safety Improvements section of this submission provides for detailed responses to manage clients' behaviour and their environment once fire risk behaviour has been identified. This individually tailored response will ensure that "categories" or "labels" do not obscure the nature of fire risk.

26 All staff at Kew Residential Services must be trained in risk management, to a level commensurate with their responsibilities. An approved risk management model such as FEMA should be used.

Agreed in part. As noted in the Fire Safety Improvements section of this submission, senior staff at KRS will attend training sessions later this year in how to conduct fire safety checks. The training will include information on specific acts and regulations pertinent to fire safety, real and potential hazards, rectification process and a site inspection.

KRS Facilities have been subject to various risk assessment models over the past years. The Eastern Metropolitan Region Occupational Health & Safety Advisor, who provides advice and consultancy to KRS, is currently reviewing the various Risk Management Assessments and frameworks in order to provide advice to KRS as to the most appropriate model to apply at the site. This review will include consideration of a model such as FEMA.

27 All Department of Human Services direct care staff should be made aware of the MFB/CFA Juvenile Fire Awareness and Intervention Programme. They should be encouraged to refer suspected or actual firelighters or those with fire risk behaviour.

Agreed. The Disability Services Policy Statement and the material available to Client Services Workers and accommodation services workers all provide information on suitable referrals, including the MFB/CFA Juvenile Fire Awareness and Intervention Programme.

28 A simple system of noting client alerts must be used so that staff can access this information easily. Alerts should not be graded but simply notify the staff member of a risk, rather than the frequency or severity of the behaviour. The current move at Kew Residential Services to access all client alerts on unit computers should continue.

Agreed. As noted in response to OPA's submission on general principles for housing people with an intellectual disability, recommendation (f), the Disability Client Information System, DISCIS, is currently being implemented statewide and is a database for recording individualised client information. A client profile can be printed for each client which includes information about whether the client has alerts which should be noted and specifies the general type of alert. Alerts may include fire risk or fire lighting behaviour, challenging behaviour including self-injurious, injury to others, dangerous sexual behaviour and property damage. There is also the capacity within the 'Alerts' section to identify individualised management strategies to address the identified behaviour. Further client information available on the DISCIS system includes identification of specific health and behaviour issues. The case note function on DISCIS will be able to be used as an on-going record within training centres units. This will enable staff to complete daily case notes on the DISCIS system as well as record 'day-night' reports.

As staff in community based accommodation services do not yet have access to DISCIS, they will continue to use a paper-based record in the form of the Accommodation Service file which contains a print-out of the DISCIS client profile and notes on any special precautions related to health and/or behaviour. It also has sections for recording on-going case notes and client management and support information.

29 The introduction of legislation to prohibit the sale of cigarette lighters not having child resistant features should be supported and a standard should be developed setting out the required characteristics of such lighters. In the interim, child resistant lighters of the kind manufactured by Bic should be made available for sale at residential care facilities.

Agreed. Under the Commonwealth Trade Practices Act 1974 the importation of cigarette lighters which do not have child resistant features has been prohibited since 1 March 1997. From 1 October 1997 the sale of such lighters will be prohibited. This legislation was introduced following agreement between State and Federal Ministers at the Ministerial Council of Consumer Affairs.

Regulations under the Trade Practices Act set out the requirements that must be met for a lighter to be considered child resistant. Australian Standards are also currently being developed in this respect.

The Office of Fair Trading is working towards adoption of the Commonwealth provisions as a priority.

In the interim, the issue of limiting the sale of lighters to child resistant lighters will be explored by Disability Services. However, it is noted that it is not possible to prohibit clients from purchasing or obtaining other lighters outside residential facilities.

30 The Government, and in particular the Department of Human Services, must develop a procedure for the regular monitoring and auditing of fire maintenance contractors. The MFB and the BSA should be involved in this process.

Agreed in part. As noted in the Fire Safety Improvements section of this submission, section 2, the Department of Human Services has engaged a consultant to develop a set of specifications for fire protection and security systems which will entail regular monitoring and auditing of the work performed under such maintenance contracts.

31 All alarm systems at Department residences must be maintained in accordance with AS1851.8.

Agreed. The Department has engaged a consultant to produce a new maintenance contract for fire protection systems in Disability Training Centres which will comply with AS1851.

32 All fire maintenance contractors who perform work at Department of Human Services Properties must be required by contract to detail in writing any proposed changes to the detection system.

Agreed. This issue will be addressed in the new specifications for maintenance contracts being drawn up for the Department outlined above. The Department will examine the suitability of this contract for use in all its residential accommodation. It is noted that the MFB may wish to raise this issue through their direct liaison with the Australian Standards Board.

33 The Department of Human Services must consider a means of intervention to identify damaged detectors and protect detectors from repeated damage.

Agreed in part. As outlined in section 2J of the Fire Safety Improvements section of this submission, the Department will require regular monitoring and auditing of fire protection systems under its new maintenance contract. However, as noted in the correspondence which has passed between the Department and the MFB (exhibit 280) without the appropriate guidance from Australian Standards as to what prevention measures are acceptable, this will be difficult. At KRS a visual check is carried out on all detectors monthly by the fire warden responsible for each unit. If concerns are raised about the state of a detector the facilities manager is contacted and the maintenance contractor is called when necessary.

34 Any maintenance at Kew Residential Services must be approved by the Chief Fire Safety Warden by way of a permit system.

Disagree. The maintenance contract currently being developed for the Department will ensure that appropriate checking and monitoring occurs on maintenance carried out on the fire safety system.

35 The Department of Human Services must ensure that a full fire audit is carried out at all residential care facilities within the next twelve months and audited annually thereafter.

Disagree. As noted in section 2 of the Fire Safety Improvements section of this submission, the Department's fire risk management strategy requires all Departmental facilities, centres and houses to undergo a fire audit.

36 The MFB should be considered as a suitable long term auditor of Department fire systems in various institutions and facilities.

To be considered. All fire audits will be tendered to appropriate contractors using the procedures required by government guidelines. The Department would welcome a tender from the MFB once called.

37 The Building Code of Australia must be reviewed to include buildings that house the intellectually disabled, but are not hospitals. A consultative approach involving experts in the care of the intellectually disabled, fire prevention experts and risk managers must design appropriate standards for fire protection for such buildings.

Agreed in part. The Australian Building Codes Board, through its representatives from state and territories, is reviewing the Class 3 and Class 9a 'nursing home' classification system at present. This process will include a 'regulation document' for public comment if changes to the BCA are considered necessary. It is noted that classification is required by the BCA and is critical where the ``deemed to satisfy'' provisions of the BCA are relied upon. Where the alternative performance based compliance method is relied upon by fire risk assessment, classification is less important.

38 That the following regulation be adopted:

- **Accommodation for the aged, disabled or children**

This regulation applies to any building which is a common place of long term or transient living for a number of unrelated persons who are aged, disabled or children.
A residential type sprinkler system complying with AS 2118.4-1994, or other equivalent fire suppression system, must be installed in the building.
Where the sprinkler system referred to in sub-regulation (2) has more than 100 heads or the building referred to in sub- regulation (1) is registered to accommodate more than 32 residents, the system must be connected to fire brigade in accordance with Building Control Commission Practice No. 7.

- **This regulation must be complied with-**
  - **within 5 years of the date of commencement of this regulation; or**
  - **at change of tenancy or management of the entire building; or**
  - **at the change of ownership of the entire building- whichever is earlier.**

Agreed in part. Proposed Regulation 5.15 of the Building Regulations 1994 is intended to come into operation on 1 August 1997 and will require AS 2118.4-1995 sprinkler systems to be installed throughout all residential care buildings (as defined) within 5 years.

39 Regulation 5.7 of the Building Regulations (1994) must be amended such that it is no longer applicable to buildings housing the aged, intellectually disabled or children.

Disagree in part. The adoption of other recommendations would render this recommendation unnecessary. Proposed Regulation 5.15 and existing regulation 5.14 of the Building Regulations 1994 adequately consider reasonable upgrade of these buildings. These apply in conjunction with any application of regulation 5.7 and therefore provides for reasonable upgrade in the time periods specified but also a provision to require earlier upgrade if building works are undertaken.

40 That all government instrumentalities and public authorities be bound by the technical, administrative and any future amendments of the Building Act and the Building Regulations.

Agreed. The Building (Further Amendment) Act 1997 will bind the crown to the building permit provisions of the Building Act 1993. This will apply to any future amendments of the Act or regulations and would be difficult to revoke as it constitutes a significant breach of the National competition policy.

41 The Fire Protection Industry must change their philosophy in relation to interim systems. Whilst acknowledging that it is the responsibility of fire engineers to develop appropriate interim systems, it seems that there is a consensus view among fire engineers that the interim systems must comply to standards or be elaborate in nature. This is not the point - interim systems are there to provide short term corrective measures for otherwise deficient systems and may comprise of simple measures. They are not meant to bring systems up to standard - a full fire upgrade may be necessary for that. A discussion paper on the role of interim or corrective measures should be developed (the Fire Services should have input into the development of such a document) so as to spark industry discussion as to the development of the interim measures philosophy.

Agreed. This is an appropriate matter for the Coroner's consideration.

42 The State of Victoria, together with the fire protection industry and the MFB, must produce a policy document outlining the requirements of various types of fire audits and fire reports expected from consultants engaged by Government departments and public authorities.

Agreed in part. Since the fire at KRS new Australian Standards have been developed in this respect. DHS has engaged consultants to provide new guidelines on this matter entitled "Fire Safety Risk Assessment Guidelines for Human Services Facilities". These are due for completion in August 1997.

43 Australian Standard AS 1851.8 must be extended to include the testing of the sensitivity of detectors. The MFB should be consulted in relation to these changes.

Agreed. The State of Victoria supports such a change.

44 Australian Standard 1603.1 of 1997 and AS1603.2 of 1987 must be amended to include appropriate mechanisms for preventing impact damage to detectors, such as the compulsory use of sensor guards in risky locations. Such sensor guards must be of the type that do not interfere with the sensitivity of the detectors. Purchasers must receive information and warnings about the risks that impact damage may have on detectors and the necessity of implementing regular testing and preventative mechanisms.

Agreed in part. The State of Victoria notes that tests undertaken by it and the CFA indicate that such guards do interfere and delay the activation of detector signals and alarms. However, the use of such guards where they are necessary must not provide hanging points which would allow material to be attached to the guard. As noted in correspondence exhibited in the Inquest this is a matter which is appropriate to be raised by the MFB with the Australian Standards Board.

45 The Department of Human Services must appoint a State Fire Safety Officer.

Disagree. As outlined in section 2 of the Fire Safety Improvements section of this submission, the Department will have a central fire risk management steering committee. This will oversee the fire risk management strategy. All regions will have a similar steering committee for their region. Disability Training Centres and houses all have fire wardens, who are responsible for emergency procedures.

46 Every Department residence or facility must appoint fire wardens for appropriate areas and a Chief Fire Safety Warden for the entire residence or facility. The Chief Fire Safety Warden shall serve on the local Fire Safety Committee.

Disagree. The Disability Services Accommodation Services Statewide Emergency Manual outlines who is responsible for fire safety under Departmental Policy.

47 The Department of Human Services must set up a task-force to design a programme to educate Chief Fire Safety Wardens as to their responsibilities. All Chief Fire Safety Wardens must receive this training before commencing in this position.

Agreed. As outlined in section 11 of the Fire Safety Improvements section of this submission, Fire warden training will be compulsory for all Unit Managers, Deputy Unit Managers and After Hours Teams in all Training Centres. The Disability Services Training Unit will offer fire warden training to all senior management in training centres and houses between August and November this year.

48 The Department of Human Services must appoint a Fire Safety Committee at every Department residence or facility, which should include Class 1b occupancies. An appropriate Fire Service Officer should serve on that committee. The Committee must be appointed and meet at least once in the next six months. The Fire Safety Committee will be charged with the responsibility of amending the generic emergency procedures (see above) for their institution and shall assist the State Fire Safety Officer in disseminating fire safety information. Once the emergency procedures have been drawn up, the Committee must meet at least once every six months. They must produce a report every six months to be distributed to the State Fire Safety Officer and the appropriate fire service.

Agreed in part. As noted in section 8 of the Fire Safety Improvements section of this submission, all Disability Services training centres will be required to establish a Fire Safety Committee which comprises both direct care and non direct care staff of the centre. Each Committee will undertake a quarterly analysis of fire drills and identify key safety issues and responses for the centre. The Manager, Client Services will establish an appropriate structure for Community Residential Services programs to ensure fire safety issues are highlighted and responded to as a priority issue. A standard fire safety manual, based on the KRS manual, will be developed for all training centres and community based accommodation in consultation with the MFB. Locality specific information will also be included in the manuals.

49 The Department of Human Services must appoint a committee to look at the appropriate design of buildings for Department residential buildings. This should be a consultative approach with appropriate experts in issues such as fire prevention and risk management. A report must be produced within twelve months outlining detail of appropriate life safety levels.

Disagree. The Department of Human Services has not appointed a committee to examine this issue. Under the Fire Risk Management Strategy all buildings owned by the Department will be the subject of a fire safety audit and matters arising from these audits will be addressed.

G. SUBMISSION ON BEHALF OF HACSU

The State of Victoria makes the following submissions with respect to the Recommendations proposed by HACSU in section C of their submission (page 7).

1. STAFF/CLIENT RATIOS

1.1 There should be a comprehensive review of staff/client ratios undertaken, in consultation with HACSU, KRS management, the Parent's Association, the MFB, and the fire detection and prevention contractors at KRS, to properly assess current staff needs, in the context of the present fire detection and prevention system.

Disagree. Staffing levels in all the Department's facilities take into account a number of factors, including response in the case of emergency. Sufficient staff are rostered to respond to client safety and care requirements.

1.2 Such a review should be on a unit by unit basis, taking into account, inter alia, the

(a) number and gender of clients in the relevant unit

(b) type and level of intellectual/psychiatric/physical disability

(c) range and gravity of challenging behaviour, in particular the risk to self,other clients and staff

(d) type of program and level of staff management required

(e) physical layout and environment of the unit

(f) capacity to evacuate clients before conditions become untenable (ie. in a matter of minutes) before buddies and/or the After Hours Co-ordination Team (AHCOT) may arrive to lend assistance

(g) classification of staff

Agreed in part. The factors outlined above are factors which are considered at KRS in the allocation of staff across the site. In addition, however, available resources and obligations under awards, are factors for consideration.

1.3 Pending such a review there should be

(a) an immediate increase in night duty staff

(b) a reversal of the policy of amalgamation of units to the extent that two Deputy Unit Managers are employed per unit

Disagree. The previous audit conducted by ULA did not recommend an increase in night staff levels. Night Staff have undertaken Fire Safety and Response training and practice fire drills regularly. The current average response time for night drills is 5.7 minutes.

As noted in response to recommendation 25 made by the Parents Association, amalgamations occurred in 1994 and the management model is considered to be effective. The current policy is that two Deputy Unit Managers are employed in Units where the number of clients exceeds 40. When the client numbers drop below 40, the number of Deputies is reduced from 2 to 1 and the Deputy is replaced by an IDSO or HSW, ie there is no nett loss in number of staff. This is considered adequate to ensure appropriate coverage and maintenance of standards.

1.4 Full 12 hour day and night shift hours should be maintained, with the most skilled and experienced staff member (ie. the Deputy Unit Manager) participating in the shift handover. Handover times must be increased to enable night duty staff to fully appreciate any identified risk factors which may impact upon the health and safety of staff and/or clients over night.

Disagree. As noted in the Fire Safety Improvements section of this submission, hand-over time has been increased to 15 minutes at beginning and end of each shift. The length of shifts is not an issue which has been considered by the Coronial Inquiry and is not an appropriate subject for a recommendation.

1.5 Only active (ie. non-sleeping) staff should be on night duty at all times. They must be able to concentrate on direct care duties, in particular the supervision, monitoring, documentation and reporting of risk behaviour. Sufficient time must be allotted for comprehensive handover to day staff, so as to ensure that communication regarding client needs and risk behaviour is at an optimum and safe level, for the full 24 hour period, seven days per week.

Agreed in part. This is a matter which is determined by line management at each facility. In all units at KRS except the House/Hostel, which runs on a community model, active night staff are employed. Supervision Policies in place in Units highlight night staff responsibilities for client care and supervision. Night staff are supported by the AHCOT Team. As noted above, and in response to other parties' recommendations, handover time has been increased and is sufficient.

1.6 In view of the reduced staff numbers at night, all night duty staff must at least have the classification of Intellectual Disability Service Officer.

Disagree. The classification of night staff was not an issue considered in the Inquest. All classifications of workers employed at KRS are capable of evacuating residents. It is important to note that AHCOT (all trained MRNs) undertake the Fire Warden function. Night staff, regardless of their classification participate in Fire Safety Response Training.

2. STAFF TRAINING AND HUMAN RESOURCES

2.1 All direct care staff at KRS should receive appropriate training in the specialty field of intellectual disability. Human Service Workers should be required to undergo the Advanced Certificate in Residential and Community Services (Intellectual Disability) or have an equivalent qualification.

Disagree. Direct Care staff includes people who are qualified Mental Retardation Nurses, Intellectual Disability Services Officers and Human Service Workers. 70% of staff are qualified MRNs and IDSOs. Human Service Workers, whilst they do not have a formal pre-service qualification, receive a 1 day pre service orientation, a 9 Day Induction program and Unit orientation.

2.2 All staff should receive training in the identification and management of clients who pose a fire risk.

Agreed in part. As noted in response to other parties' recommendations, the Disability Services Policy Statement and associated strategies will ensure that all staff are alerted to the need to assess fire risk and implement strategies to address it where it exists. Training and information on managing the risk is available.

2.3 Adequate replacement staff must be made available to permit staff to attend study or training.

Agreed. When staff attend formal training "backfill" is usually provided, ie the staff member is replaced. All Units have a Unit casual pool to draw from for staff replacement.

2.4 All new staff must have a comprehensive induction and orientation.

Agreed. All new staff receive both pre service orientation, Unit orientation and formal induction programs. All of these are compulsory for KRS staff.

2.5 Sufficient staff resources must be made available to enable all direct care staff to fully familiarise themselves with the contents of client files. Familiarisation and regular review must be carried out in a systematic way, to take account of staff rosters, transfers of staff or clients between units, and changes in staff due to holiday, sickness or turnover.

Agreed. Sufficient staff are now provided for this to occur. All staff are required to be familiar with the information they need to effectively care for and supervise clients. This includes client alerts, IPPs and GSPs. A number of initiatives have occurred to facilitate this.

i. DISCIS - new, user friendly, computerised client information system.

ii. Review of KRS Key worker system to clarify roles and responsibilities.

iii. Revised Accommodation Services File was introduced in 1995.

2.6 As staff may be called to attend an emergency in another unit at any time, each staff member must have an up to date knowledge of the physical layout of all units, and the appropriate fire evacuation procedures for each unit.

Agreed. As noted in section 10 of the Fire Safety Improvements section of this submission, a buddy orientation system has been introduced for both day and night staff. This involves staff in each 'loop' visiting other Units in the 'loop' to familiarise themselves with Unit lay-out and clients.

Unit Floor Plans are displayed at all main exists.

3. STAFF AWARENESS OF OCCUPATIONAL HEALTH AND SAFETY RISKS

3.1 HACSU and staff must be consulted during the course of any fire audit.

Agreed in part. HACSU and staff will be informed of relevant outcomes of any fire audit and consulted where appropriate in implementing any changes which impact on staff.

3.2 All reports which touch upon the occupational health and safety of staff, in particular the contents of any fire audit reports, must be provided to HACSU and staff. Staff must have a full appreciation of the risks inherent in their working environment.

Agreed in part. KRS has an OH&S Committee where issues can be raised and discussed. KRS also meets with HACSU on a monthly basis to discuss issues/concerns. These issues can be discussed in these forums.

H. SUBMISSION ON BEHALF OF BSA

The State of Victoria makes the following submissions with respect to the Proposals for Management of Essential Services Systems made by BSA in section E of their submission (page 39). To the extent that Sections E 1 to 3 of the submission made by the BSA articulates the "vision" of BSA the State of Victoria makes no response. It notes:

1. that BSA is a service agency of the Department of Infrastructure, and that any implementation of that vision (or other matters raised throughout the whole of section E of the submission) through government policy would require full and proper consideration of the implications for the whole of government; and

2. that many of the issues raised by the BSA throughout the whole of section E are not issues or matters which have been raised through evidence or pursued through the Inquest.

   These matters would have to be the subject of comprehensive consultation with the whole of government and cannot be the subject of a considered response in the time currently available to the State of Victoria.

E.1 BSA'S VISION

E.4.1 Compulsory audit of premises within specified time-frame. Some Departments currently undertake audits to record and review the condition of buildings and/or compliance with regulations. BSA undertakes such audits for a number of clients who are then in a position to develop programs for maintenance and upgrade works based on the audits.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.4.2 So that outcomes are consistent, audits should use a common format which will make the task easier and enable best of the result.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.4.3 Strategic mandatory ongoing inspections (spot checks). BSA offers to clients the service of systematically auditing buildings but to take this step further, such audits could be compulsory and ongoing so that implementation of audit findings is also reviewed and the condition/compliance issues are re-visited.

Due to time constraints the State of Victoria makes no response to this recommendation. However, the State of Victoria notes that the Department of Human Services is compiling a register of appropriately qualified building surveyors to allow the Department to undertake ongoing monitoring of its facilities.

E.4.4 Building permit for new fire protection systems and other essential services. This is currently required but the process could be enhanced by incorporating requirements for future maintenance.

Disagree in part. The Building Act requires a building permit for installation of any fire protection systems. This should then be added to the buildings existing essential services listing on the occupancy permit and level of maintenance performance nominated.

E.4.5 Certificate of compliance with relevant Australian Standard called up in the BCA for existing fire protection systems within a specified time-frame. This would involve expert appraisal of existing systems within, for example, a period of two years, to identify works required to ensure compliance with the relevant Australian Standards.

Disagree. The State of Victoria notes that the Department of Human Services is currently undertaking audits for all Departmental facilities which will address compliance with the relevant Australian Standards. The maintenance contracts being developed as outlined in section 2J of the Fire Safety Improvements section of this submission will also require verification of existing security and fire safety systems. The BCA relates to technical provisions for new buildings only and as such could not include any retrospective matter relating to existing fire protection systems. The Building Regulations 1994 can include such a provision. The Building Regulations Advisory Committee established under the Building Act 1993 includes representatives of the fire brigades, Office of Building, building surveyors, engineers and architects. This committee could consider any issues relative to retrospective checking of existing fire protection systems.

E.4.6 BSA would support regulatory changes needed to implement the above recommendations.

The State of Victoria makes no response to this statement.

E.4.7 Existing bodies and approval systems could be utilised for these purposes, for example, BCC and BPB.

As part of BSA's term maintenance product, it will offer clients a report on their essential services for the purpose of the client complying with Part XI of the Building Regulations 1994. BSA also offers clients advice as to how to close the gap between what exists in the building and what is required by law.

The State of Victoria makes no response to this statement.

E.5 HARDWARE REQUIREMENTS

E.5.1 BSA supports proposed regulations (expected to take effect from 1 August 1997) requiring supported residential care buildings to be fitted with sprinklers within five years. It would further assist if amendments were made to the Building Regulations or BCA clarify precisely which class of buildings are required to comply with the particular fire safety requirements. For example, there is confusion about whether certain residential care buildings should be classified as class 1b, class 3 or class 9 buildings.

The Department of Human Services recognises that the classes under the BCA may not clearly apply to its facilities. For this reason the Department is currently producing guidelines for fire safety in all Departmental facilities. The guidelines address and identify each of the different categories of residences which house people receiving services from the Department and provide for appropriate levels of fire safety equipment. Proposed Regulation 5.15 of the Building Regulations 1994 is intended to come into operation on 1 August 1997 and will require AS 2118.4-1995 sprinkler systems to be installed throughout all residential care buildings (as defined) within 5 years.

The BCC has specifically drafted the proposed regulation without reference to the BCA classification system so as to take account of changing building use and terminology. For example the Commonwealth funding description of 'nursing home' has now been removed and all such buildings are referred to as 'residential care'. The BCC is addressing this in a practice note to all registered building practitioners proposed to be published in August 1997.

The Australian Building Codes Board through its representatives from states and territories is reviewing the Class 3 and Class 9a 'nursing home' classification system at present. This process will include a 'regulation document' for public comment if changes to the BCA are considered necessary.

E.5.2 BSA recommend extending the requirement for sprinklers to ensure that all residential care buildings are covered. See paragraph E.5.1 also.

As noted in the response to E.5.1 above.

E.5.3 Hardware systems should appropriately balance the needs of warning and control of fire.

Due to time constraints the State of Victoria makes no response to this recommendation. It is noted that fire engineering analysis of larger facilities provides an appropriate fire protection system to meet both client needs and to balance warning and control of fire.

E.5.4 The building approval system should be used to support and enforce these initiatives so the building surveyor has a role in ensuring compliance.

The engineering solutions from all fire engineering analyses carried out for the Department of Human Services are required to be verified by a building surveyor as part of the Department's standard brief for consultants. As mentioned previously, regulation 5.14 and proposed regulation 5.15 provide a significant legislative framework for residential care buildings. The enforcement mechanism will be via municipal building surveyors and the relevant fire brigades. This provides substantial enforcement power over a wide network of enforcement officers.

E.5.5 The Australian Building Codes Board (ABCB) or the BCC may be well placed to review and if appropriate adopt Australian Standards or other appropriate codes or standards for determining requirements.

The Department of Human Services is discussing with the BCC the process for ratification of the guidelines produced by the Department so that they can be deemed to satisfy the BCA.

E.6 RISK ANALYSIS AND MANAGEMENT STRATEGIES

E.6.1 Recognise the need for comprehensive risk analysis and the development of appropriate strategies to control risk. VMIA is legislative initiative for risk management which could include these matters and extend to building safety and risk management pre-construction, for ongoing maintenance and upon any change of use of the building.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.6.2 Consideration has been given to the NSW Government policy of government funded projects to implement risk management plans. However it should not be only monetary value of works that determine when risk management is required but also safety consequences of the project eg fire protection works should always be subject to a risk management plan irrespective of their value. The Victorian government has chosen the VMIA approach instead but the NSW system will provide interesting comparison.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.6.3 Develop personnel management strategies for prevention, warning, response (including evacuation) and control of fire, to be integrated with and supplement hardware systems.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.6.4 Interim risk management measures should be determined and putting place while permanent hardware and personnel management requirements and strategies are developed and implemented.

Due to time constraints the State of Victoria makes no response to this recommendation. It is noted that the Department of Human Services' standard fire audit/risk analysis brief to consultants requires the fire engineer undertaking the audit to identify interim works for implementation after the audit but before the risk analysis.

E.6.5 Building, systems and use changes should be implemented pursuant to and consistent with a determined strategy, rather than in an ad hoc manner.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.6.6 Risk analyses should be first undertaken to ensure safety of occupants in relation to all proposed building works, including renovations and refurbishment, to ensure fire protection is not compromised by those works taking into account the works, the change of use etc. The building permit and occupancy permit should be used as tools to reinforce this by referring to the risk analysis.

Due to time constraints the State of Victoria makes no response to this recommendation. It is noted that under the new performance based BCA to be introduced in August this year this would be carried out by an appropriately qualified building surveyor.

E.6.7 There is also reference to "alternative solutions" under the proposed Regulations - see clause 1.8 and 2.1 (7) on pages 5 and 6 of the draft of the proposed Building (Further Amendment) Regulation 1997.

Alternative solutions are the means of determining compliance with the new performance based BCA96, other than by the deemed-to-satisfy provisions. This process requires use of prescribed assessment methods and includes equivalence to the deemed-to-satisfy, test reports, certification etc. The level of safety provided is equal to or greater than that required by the performance requirement.

E.6.9 Adapt BSA's Occupational Health and Safety System (or a similar system) for major projects so it can be generally adopted for minor works and maintenance contracts where the system an be seen to produce safety benefits both in the undertaking of the works and ensuring quality of the works. BSA seeks to assist its clients in meeting their obligations under section 22 of the Occupational Health and Safety Act 1985.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.6.10 A program of awareness and education about legal obligations and compliance methods could assist interested stakeholders involved in the provision and maintenance of fire protection systems (including owners, agents, staff, contractors and consultants).

Due to time constraints the State of Victoria makes no response to this recommendation.

E.6.11 Recommend use risk management principles relating to awareness and compliance as a key criterion in the selection of consultants and contractors

Due to time constraints the State of Victoria makes no response to this recommendation.

E.6.12 BSA recommends that any changes in use must be taken into account during the annual inspection of essential services required under Part XI of the Building Regulations.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.7 CONTRACT SPECIFICATIONS

E.7.1 ABCB may be the most appropriate body to review all available standards and codes to determine specifications for design installation and maintenance of fire protection systems which will be most likely to ensure ongoing integrity and effective operation of such systems.

Disagree. The ABCB through its representatives from each state and territory, determines the specifications (typically Australian standards) for design of fire protection systems. This is reflected in the provisions of the BCA. Issues of ongoing maintenance are a state issue usually included in the relevant building regulations. In Victoria this is Part 11 of the Building Regulations 1994 which has requirements for listing of essential services, including a specified level of performance of the maintenance, on occupancy permits. In existing buildings Part 11 requires that all safety equipment, fittings etc be 'fit for purpose' at all times.

E.7.2 BSA recommend the inclusion in contract specifications of requirements for compliance with the measures and outcomes determined in accordance with paragraph E.7.1 above requirements for the contractor to provide evidence of and the contract administrator to audit the use of effective management systems designed to achieve and verify specified outcomes.

This will encourage a healthier contracting environment.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.7.3 As an alternative, ensure specifications make sufficient provision for auditing the works (which is currently not an industry standard practice) and enforcement of compliance.

Due to time constraints the State of Victoria makes no response to this recommendation. It is noted that the Department of Human Services is currently considering whether such audits should be carried out by appropriately qualified building surveyors as a matter of standard policy.

E.7.4 Ensure clarity and consistency of specifications, particularly in the areas of delineation of respective authorities and responsibilities, communication, record-keeping, supervision, systems and performance auditing, and risk analysis and management. Where appropriate, standard specifications could be developed for use across a range of Departments and agencies as is happening in a number of other areas at present.

Due to time constraints the State of Victoria makes no response to this recommendation. It is noted that the guidelines currently being produced by the Department of Human Services will ensure such clarity and consistency.

E.8 QUALIFICATION OR LICENSING

E.8.1 BSA recommends the implementation of a system of qualification or licensing of consultants involved in the design, installation and maintenance of fire protection and other health or safety systems, by reference to criteria including technical, managerial and financial capabilities.

Disagree. The Building Act requires all designers (including architects, engineers and draftspersons) and builders (installers) to be registered building practitioners. This includes a specified level of qualification and experience and compulsory insurance. It would seem a duplication to instigate a separate system for installation of fire protection systems only. Registration includes access to the BCC information service and training workshops, seminars etc. The building permit process also includes independent review and approval by a registered building surveyor (who must also be insured) and final inspection sign off. The Department of Human Services requires qualifications equivalent to Australian Fire Safety Accreditation Board or Institute of Engineers for all fire safety practitioners.

E.8.2 Training and certification of relevant personnel should be a requirement for qualification or licensing of consultants and contractors.

As above.

E.8.3 The existing registration responsibilities and functions of the Building Practitioners Board (BPB) under the Building Act 1993 could be extended to consultants and contractors involved in the design and works relating to fire protection, and other health or safety related systems.

See above.

E.8.4 The BPB and agencies could utilise and rationalise existing and propose databases of fire protection or other health or safety practitioners maintained by various organisations and agencies and Departments such as Office of Building & Development, Department of Human Services and the Institution of Engineers.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.8.5 As proposed in E.8.1 above use awareness and compliance with risk management principles as a key criterion in the qualification, licensing and selection of fire protection practitioners.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.9 CONTRACT ADMINISTRATION AND COMMUNICATION

E.9.1 Terms of engagement, task identification and delineation of respective roles, authorities and responsibilities should be agreed and clearly recorded in formal documentation between the owner and all agents, consultants and contractors.

Agreed. The new contract specifications being produced for the Department of Human Services will clarify these matters.

E.9.2 As proposed in E.7.4 above, contract specification should make clear provision for a delineation of authorities and responsibilities for the proper administration of fire protection systems works and maintenance contracts.

Agreed. The new contract specifications being produced for the Department of Human Services will clarify these matters.

E.9.3 By means of both contract specification and implementation of practical strategies, there should be measures in place for formal and informal communication between all parties to fire protection works, including the owner, agents, consultants, contractors and the Metropolitan Fire Brigades Board.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.9.4 The contract specification and practical strategies, should be used to ensure the recording of all communications and reports (formal or informal) and mechanisms for follow up action or responses.

Agreed. The new contract specifications being produced for the Department of Human Services will clarify these matters.

E.9.5 Term Maintenance guidelines and supporting software data management systems have been developed by BSA which may be used or adopted for fire protection systems maintenance to ensure all parties are aware of the contractual obligations of the parties, processes and outcomes required by the contact and methods of fulfilment.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.9.6 The owner, as Principal to a fire protection systems work or maintenance contract, should ensure the identification of the precise extent and outcomes of the proposed works, to ensure that there are not any misunderstanding which may result in no-one understanding what may be key components such as auditing or performance review.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.10 INFORMATION SYSTEMS FOR RETAINING AND ANALYSIS

E.10.1 Various recommendations have been made above for the gathering and retention of information, and they are emphasised as being critical to the proper assessment and management fire risks.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.10.2 It is necessary to have current, extensive and accurate information about the nature extent location and condition of componentry of fire protection systems and this means that it is critical to have systems for the gathering analysis and retention of information which is then readily accessible.

Due to time constraints the State of Victoria makes no response to this recommendation.

E.10.3 BSA has developed proprietary software for the computer-aided gathering, analysis, retention and generation of information in relation to building services. This software may be adapted for valuable use in relation to essential services systems.

Due to time constraints the State of Victoria makes no response to this recommendation.

APPENDIX 4.3 VILLAMANTA LEGAL SERVICE RESPONSE TO PARTIES' RECOMMENDATIONS

1. PART 1

1.A INTRODUCTION

In this submission VLS will examine the recommendations submitted by the parties in the first round of submissions.

VLS notes that the Department of Human Services did not include recommendations in its first round of submissions. VLS has sought and been promised these recommendations by 27 June 1997 .They have not been provided at the time this submission is being completed. This gives rise to serious concerns. The Department's recommendations are likely to have direct impact on client welfare. This is of paramount interest to VLS and our constituents.

VLS seeks to reserve the opportunity to comment on any recommendations made by the Department in its second round of submissions.

Since the completion of the hearing of evidence, it has been reported in the press that the Department has closed the double storey Units 7 and 8 which were a cause of serious concern to VLS. It has also been reported that in the long term that Kew Residential Services will be closed and the residents will be accommodated in the community in accordance with the principles of the Intellectually Disabled Persons Services Act 1986.

VLS submits that the Department should advise Your Worship, if it has not already done so, of the veracity of these press reports and also give Your Worship an indication of the time frame involved. Recommendations involving capital expenditure at Kew should be seen in the context of this development if it is true.

VLS welcomes this development however VLS submits that until residents are moved Kew must be made safe.

1.B STRUCTURE OF THESE SUBMISSIONS

VLS has compiled all the parties' recommendations set out in the first round of submissions. These are set out in Appendix A attached hereto. These are also provided to Your Worship on computer disk (Microsoft Word 6 for Windows format). Appendix A has not been supplied to other parties as it is merely a compilation. If the parties seek a copy of Appendix A they may apply to Mr. Ian Parsons at VLS who will arrange for it to be sent to them.

VLS has structured the parties' recommendations into five major categories for ease of comparison and evaluation. These categories are:

A Physical Surroundings

B Human Resources

C Fire protection Industry

D Building Industry

E Conscientisation in fire issues.

VLS has provided comment in each of the categories and in many subcategories.

The categorisation of recommendations has been difficult as they often transcend one category. Accordingly some have been entered in more than one category. VLS hopes that the categorisation is of assistance to Your Worship.

VLS has also provided a copy of this categorisation of and comment on the recommendations to Your Worship on the same computer disk.

2. PART 2.

2.A PHYSICAL SURROUNDINGS

2.A.1 "Norms and patterns valued in the general community"

The MFB recommendations with respect of the Building Code of Australia in this section are predicated on institutional living continuing for people who have an intellectual disability. The OPA recommendations indicate that such care, called "congregate care", is inappropriate and unsafe. VLS submits that institutions are contrary to the principles of the IDPS Act.

VLS submits that people who have an intellectual disability should live in the community. Until this process is completed and properly resourced, institutions will continue. VLS recognises the common sense of the MFB recommendations but would not want this to be an imprimatur that such is really an appropriate way to accommodate such persons in the long term.

MFB 37 The Building Code of Australia must be reviewed to include buildings that house the intellectually disabled, but are not hospitals. A consultative approach involving experts in the care of the intellectually disabled, fire prevention experts and risk managers must design appropriate standards for fire protection for such buildings.

MFB 38 That the following [building] regulation be adopted:

* Accommodation for the aged, disabled or children -

This regulation applies to any building which is a common place of long term or transient living for a number of unrelated persons who are aged, disabled or children.

A residential type sprinkler system complying with AS 2118.4-1994, or other equivalent fire suppression system, must be installed in the building.

Where the sprinkler system referred to in sub-regulation (2) has more than 100 heads or the building referred to in sub-regulation (1) is registered to accommodate more than 32 residents, the system must be connected to fire brigade in accordance with Building Control Commission Practice No. 7.

This regulation must be complied with:

(a) within 5 years of the date of commencement of this regulation; or

(b) at change of tenancy or management of the entire building; or

(c) at the change of ownership of the entire building - whichever is earlier.

MFB 39 Regulation 5.7 of the Building Regulations (1994) must be amended such that it is no longer applicable to buildings housing the aged, intellectually disabled or children.

OPA (1a) In recognition of the increased risk of fire and associated life-endangering phenomena posed by the characteristics of large congregate care residences, people with intellectual disabilities should be housed in units of a size comparable to domestic residences in the general community.

OPA (1b) Residences should be designed in recognition of the fact that the fewer residents, in general the safer the residence is for those residents.

OPA (1l) The size of a residence should be proportionate to the number of residents living within it because of the safety risks of large or inappropriately designed residences.

VLS 8 People who have an intellectual disability, particularly those living at KRS, should, in order to minimise risk and ensure safety, live in accommodation which is consistent with Principles of the IDPS Act.

VLS 9 Renovating KRS to ensure such minimisation of risk will be costly, and we note that any funds spent on such renovations are funds spent on the maintenance of a facility with a necessarily limited life-span, and we therefore suggest that the thrust of Your Worship's recommendations should be towards the relocation of KRS residents into smaller settings throughout the community.

2.A.2 Fire Safety Hardware

2.A.2.1 Fire Detection.

The importance of early warning of fire has been underlined during the hearing. The appropriateness of the detection system is determined by the use and construction of the room or building. Early detection is important not just in residential care facilities but generally in homes in the community.

The MFB raises concerns about false alarms and damage to detectors which may go undetected and incapacitate the system. Sensor guards may be necessary but must be designed to be sympathetic to the principle of "homelike environment".

KPA 3. A comprehensive system of hard-wired smoke detectors, hard-wired thermal detectors and break-glass alarms should be installed throughout the facility in accordance with AS1670.

MFB 1. A system of smoke alarms must be installed in all residential care facilities. In the case of a class 3 and class 9a building the system must comply with AS1670-1993 and in the case of a class 1 building the system must comply with AS 3786-1993. These recommendations are to be made retrospective with works being completed within an acceptable time frame, say 5 years. Note 1: This may require the replacement of thermal detectors with smoke detectors/alarms. Note 2: The standard of alarm system required will be dependent on the coverage provided by a sprinkler system.

MFB 2. Where false alarming is occurring in a smoke detector system, systematic and appropriate remedial action must be taken, while ensuring that smoke detectors are not inappropriately changed for thermal detectors as a solution to the problem.

MFB 43 AS 1851.8 must be extended to include the testing of the sensitivity of detectors. The MFB should be consulted in relation to these changes.

MFB 44 AS 1603.1 of 1997 and 1603.2 of 1987 must be amended to include appropriate mechanisms for preventing impact damage to detectors, such as the compulsory use of sensor guards in risky locations. Such sensor guards must be of the type that do not interfere with the sensitivity of the detectors. Purchasers must receive information and warnings about the risks that impact damage may have on detectors and the necessity of implementing regular testing and preventative mechanisms.

OPA (2a) There should be hard-wired addressable smoke detectors in all rooms of all residences to maximise the early detection of fires.

2.A.2.2 Local Alarms

The recommendations do not distinguish between types of buildings used for accommodation for people who have an intellectual disability. For all types of residence, be it a Community Residential Unit or a unit at an institution, a local alarm is necessary. In an institutional setting the alarm should be sympathetic to the principle of "homelike environment".

KPA 4. Every residential unit should have a local alarm system with:

(a) an alarm bell; and

(b) a local mimic panel;

which identifies for carers (both within the unit and at the administration panel) the location of the detector in alarm.

MFB 8. If it necessary for residential care facilities to be provided on a secure basis then it is critical that automatic sprinklers and a local alarm system be provided in such premises.

OPA (2b) There should be residence-based alarms for all residences triggered by smoke detector activation to enable early warning to residents and staff of fires.

2.A.2.3 Sprinklering

Sprinklering of residential premises is now valued in the community. The MFB recommends full sprinklering of all residential care facilities. KPA recommend that sprinklering is relevant to safety rather than class of building.

Both Wormalds and MFB recommend full sprinklering of Kew. VLS supports sprinklering for those residential units which will still be open at the end of 1998.

OPA recommends sprinklering where rapid evacuation is not possible. VLS notes that ease of evacuation can be reduced through any of a number of factors, including the physical layout of the premises, the nature of the disabilities of the people living there, and the number of staff available to assist in the evacuation.

Given the expense of sprinklering, VLS suggests that the OPA recommendation is a practicable system of prioritising until sprinklering as the MFB recommends is achievable.

KPA 2. All residential buildings should be fully sprinklered to appropriate Australian standards.

MFB 6. Residential institutions must have a sprinkler system that complies with the minimum requirements of AS2118.4 of 1995 installed in all compartments including roof spaces where fire separation is not provided for. Sprinklers must be installed at all residential care properties, regardless of their classification. This is particularly important following the move to integrate the mentally disabled into the community and move them directly into class 1b occupancies. It should be noted that buildings in this classification can still retain security mechanisms such as bars on windows, locked doors and polycarbonate glazed windows. These recommendations are to be made retrospective with works being completed within an acceptable time frame of 5 years. Fire separation of compartments excluded from sprinklers should only occur in accordance with section 2: 10AS 2118.4 of 1995.

MFB 8 If it necessary for residential care facilities to be provided on a secure basis then it is critical that automatic sprinklers and a local alarm system be provided in such premises.

MFB 9 The system of sprinklers to be installed in residential care facilities should be a complete - not partial - automatic sprinkler system. Where there is not complete sprinklering then there must be fire separation at compartments excluded from sprinklers in accordance with AS 2118.4 1995, clause 2.10.

MFB 10 All units at KRS where there is partial sprinklering must be upgraded to full sprinklering as soon as possible with Unit 7/8 receiving immediate priority.

OPA (2c) There should be full sprinklering for all residences, where rapid evacuation is not possible, to maximise the potential for early extinguishment of fires.

VLS 3 That staff be made aware of the limitations of the fire sprinkler system and that the sprinklering of the double storey unit be extended to cover the entire premises.

WOR 4.10 The buildings should be fully sprinklered. This would avoid the danger of fire developing in the unsprinklered area of a building to a point where it cut off fire escape doors and/or overwhelmed the sprinklers in the sprinklered areas.

2.A.2.4 Compartmentation

VLS notes that compartmentation issues are also mentioned in the previous section dealing with sprinklering.

KPA 6. Fire and smoke compartmentation to BCA standards.

KPA 14. In the construction of new, or the renovation of old, units, building standards at KRS must conform to the applicable building codes and fire regulations. Fire walls should separate adjoining flats and walls and ceilings should consist of fire resistant materials, wherever possible.

OPA (2i) There should be adequate fire and smoke compartmentation within residences in accordance with the Building Code of Australia.

2.A.2.5 Electronic dissemination of information – pagers, panels mimic panels, AIU, phones, Public Address

The recommendations in this section almost exclusively apply to the situation arising at Kew. The major problem remains the transmission of information about which detector is in alarm from the FIP at the administration building to the personnel in the unit affected. VLS recommends the FIP should be monitored at all times until a solution is found.

Wormalds suggest a solution that each unit have a FIP instead of a mimic panel.

VLS supports Wormalds' recommendations that until the matter is solved that mimic panels zones replicate "flats' within buildings in such buildings where the flat system operates.

The MFB's desire to ensure the full addressability of the new fire system at Kew is supported by VLS. VLS notes that the numbering of rooms in buildings is contrary to the principle of "homelike environment". So long as there is a map which indicates detector numbers, rooms can be identified easily.

VLS also does not consider that the KPA public address system option is consistent with "homelike environment" . VLS submits that until it is demonstrated that such a system would dramatically improve safety it should not be adopted.

The OPA suggestion that all residences should have AIU would be inappropriate in Community Residential Units. The advantage of small scale accommodation is the capacity to deal locally with such matters. The AIU option is appropriate in institutional settings.

KPA 4. Every residential unit should have a local alarm system with:

(a) an alarm bell; and

(b) a local mimic panel;

which identifies for carers (both within the unit and at the administration panel) the location of the detector in alarm.

KPA 5 The backup system of alarms in buddy units should be reprogrammed to ensure that the closest units to each affected building are on the same loop. The loops should be overlapping.

KPA 10 A public announcement system dedicated to emergency communications should be installed throughout the complex.

MFB 3 The current problems with the alarm system at KRS must be resolved as a matter of urgency. The system must be made fully addressable and identify room numbers, rather than zones; at the very least the system should be programmed to perform at the best of its capabilities. Maps showing the room numbers should be installed next to the mimic panels and the main alarm panel. Rooms should be marked with room numbers so as to familiarise staff with those numbers. The AHCOT team must receive notification on their pager of the location of the unit in alarm.

OPA (2e) There should be an AIU facility to the Metropolitan Fire Brigade in all residences.

OPA (2f) There should be mimic panels in each residence to enable staff to ascertain speedily the location of activated smoke detectors.

VLS 4 The Coroner be kept informed about the technical developments despite the ending of the Inquest.

VLS 5 If the technical difficulties are insuperable, VLS again suggests that Your Worship recommend that the fire indicator panel be monitored at all hours.

WOR 4.3 The programming of the loop system at KRS should be altered from the present system which is dependent on the loop on which the building is located. Buildings contiguous to the building where the alarm has gone off should register that alarm on their mimic panels and by the activation of their lights and hooters.

WOR 4.4 The mimic panels in the buildings at KRS are not capable of identifying the detector that has gone into alarm. They presently identify a zone number which can then be located by reference to a map (e.g. zone 2021 might be Flat B in Building 37). The programming on the mimic panels should be altered so that the display shows the Flat number rather than the zone number.

WOR 4.5 To allow identification of the particular detector that has gone into alarm from every building, it would be necessary to replace the mimic panels with FIPs in each building and to program them into the system. If this were done, all the FIPs (i.e. the main FIP and all the building FIPs) would have text identifying the room in alarm. This would be an improvement on the existing information on the main FIP which can only show the number of the detector in alarm. To identify the room in alarm currently requires reference to the map folder at the main FIP. The cost of this would be substantial. The FIPs cost $3,000 per unit plus the cost of installation and programming.

WOR 4.7 At present, the only place from which it is possible to identify the detector and room in alarm is from the main Fire Indicator Panel. It would be possible to have a pager system with the present equipment which would allow the zone in alarm to be identified (and if the zones were re-programmed to show flats, the Flat in alarm). If the mimic panels were replaced by FIPs, the pager would then also be able to identify the detector in alarm. Until some such solution is in place, there should always be a staff member on duty at the main administration building who can obtain information about the detector in alarm immediately from the main FIP. This is particularly relevant to the after hours situation where only two members of staff are at the administration building.

WOR 4.8 The possibility of pagers which would allow night staff to identify the Flat in alarm or the detector and room in alarm from locations away from the main FIP - as outlined in 4.6 - should be investigated.

2.A.2.6 Maps

The Inquest has revealed the importance of good maps of units in residential institutions. VLS notes that the display of maps at all residences as recommended by OPA is inconsistent with norms in the general community. It should be a requirement dependent on the size of the accommodation and the complexity of the layout of the building.

OPA (2j) Maps of the structure of residences should be prominently displayed within a prominent area of all residences, as recommended by the Metropolitan Fire Brigade.

OPA (2k) Maps of the structure of residences should be provided to the Metropolitan Fire Brigade.

2.A.2.7 Maintenance

The maintenance recommendations fall into 2 areas. The first is the Department's approach to securing the services of maintenance contractors. ULA suggests an accreditation scheme.

The balance of recommendations relate to Kew itself. Concern is raised about the use of 2 maintenance contractors at present.

Various recommendations relate to the oversight of work which is uniformly considered to be best performed locally.

VLS supports these recommendations and that regarding the documenting and oversight of changes to the current system at Kew. The MFB recommendation regarding work permits may assist the oversight of work on the system.

KPA 52 A full review of the fire protection maintenance contracts at KRS should be urgently performed by DHS, KRS management and the KRS Fire Committee.

KPA 53 There should be one maintenance contractor for all residential buildings at KRS.

KPA 54 The maintenance contract should be directly with KRS and should be overseen by the CEO, Chief Fire Warden and the Fire Committee.

KPA 55 Funding for the maintenance contractor should be reviewed after consultation with the appointed fire auditor.

KPA 56 Quality control (and auditing for compliance with Australian standards) of the fire maintenance contractor should be conducted by KRS, the Chief Fire Warden and the Fire Committee with regular input from the MFB and a properly appointed fire engineer.

KPA 59 All fire prevention maintenance should be conducted in accordance with the Australian standards and the Building Regulations should also be adhered to regarding maintenance of fire safety systems.

KPA 60 The Parents' Association is very disturbed by the fact that Jonkar Pty Ltd has recently "upgraded" unit 24, has been considered for unit 23 and is responsible for the ongoing maintenance of unit 24. Concerns relate to the competence of Jonkar Pty Ltd generally as well as the problems which may arise from having dual maintenance contractors on the site and often operating from the one fire panel.

MFB 30 The government, and in particular DHS, must develop a procedure for the regular monitoring and auditing of fire maintenance contractors. The MFB and the BSA should be involved in this process.

MFB 31 All alarm system at Department residences must be maintained in accordance with AS1851.8.

MFB 32 All fire maintenance contractors who perform work at DHS properties must be required by contract to detail in writing any proposed changes to the detection system.

MFB 33 DHS must consider a means of intervention to identify damaged detectors and protect detectors from repeated damage.

MFB 34 Any maintenance at KRS must be approved by the Chief Fire Safety Warden by way of a permit system.

OPA (3b) Sufficient auditing and monitoring processes, at regular intervals, should be employed to ensure that the safety technologies installed in the residences continue to function at an acceptable level.

ULA M 1[1] An accreditation scheme for Government building fire system maintenance contractors should be introduced.

ULA M 2 Government building fire system maintenance contracts should be awarded only to accredited maintenance contractors.

ULA M 3 Maintenance contractors will remain accredited only if they operate a quality assurance system with proper record keeping and work procedures.

ULA M 4 Accredited maintenance contractors are required at all times to adhere to Australian standards AS 1850, and will be subjected to periodic quality audits by the accreditation authority.

WOR 4.1 The practice of two contractors working on the same fire detection and protection system (by way of alteration, or service and maintenance) is prone to confusion and highly irregular in the fire protection industry. Wormald strongly recommends that it should cease.

WOR 4.2 If recommendation 4.1 is rejected and the system of using two contractors is to continue, there should be a system whereby the work done by each contractor is fully documented and provided to the other contractor immediately and there should be monthly meetings between KRS and the two contractors to exchange information about the operation and updating of the system.

2.A.2.8 Fire Extinguishers etc.

KPA 12 Fire fighting equipment to extinguish or contain spot fires should be installed in accordance with the Building Regulations in all units and be readily accessible at all times.

KPA 13 Such [extinguishment] equipment should be regularly audited by the MFB.

1 In ULA numbering, the letter "M" refers to "Maintenance".

2.A.3 Materials

2.A.3.1 Building materials

VLS supports the recommendations that require the application of Building standards, codes and regulations to Government owned buildings.

Where there is a perceived need for restraint of residents because of their disability, such must be dealt with in accordance with the principles set out in the IDPS Act. Much evidence was given to Your Worship about challenging behaviours. In limited circumstances technological resolutions may be necessary to deal with such behaviours. Any such action must be taken in conjunction with an overall plan for the person as detailed in his or her GSP. Technological solutions, such as bars on windows or locked doors or polycarbonate glazing should only be considered when no other less restrictive option is available and must always be reviewed in response to other strategies directed at resolution of the challenging behaviour.

Technological solutions, such as the use of fibron, may prevent damage to walls but also have fire enhancement capacities. The consequences of the type of building solutions to challenging behaviours must be scrutinised.

KPA 14 In the construction of new, or the renovation of old, units, building standards at KRS must conform to the applicable building codes and fire regulations. Fire walls should separate adjoining flats and walls and ceilings should consist of fire resistant materials, wherever possible.

MFB 6 Residential institutions must have a sprinkler system that complies with the minimum requirements of AS2118.4 of 1995 installed in all compartments including roof spaces where fire separation is not provided for. Sprinklers must be installed at all residential care properties, regardless of their classification. This is particularly important following the move to integrate the mentally disabled into the community and move them directly into class 1b occupancies. It should be noted that buildings in this classification can still retain security mechanisms such as bars on windows, locked doors and polycarbonate glazed windows. These recommendations are to be made retrospective with works being completed within an acceptable time frame of 5 years. Fire separation of compartments excluded from sprinklers should only occur in accordance with section 2: 10AS 2118.4 of 1995.

2.A.3.2 Furnishings

The minimisation of fire loads is important for safety. VLS submits that often residents at Kew buy or are given bits and pieces for themselves or the place is decorated in ways which increase the fire load, such as putting up paintings. Again the balancing principle is the aim to create a homelike environment consistent with norms in the community.

OPA (2d) Fuel loads should be kept to levels consistent with safety.

2.A.4 Security, egress and evacuation.

VLS agrees with recommendations for a single key system for all Department residences including Community Residential Units.

How to ensure easy egress from a building will vary from building to building. Building egress should comply with the standards set out in the Building Code of Australia.

The use of automatic door releases is necessary when clients are locked in. VLS understands that automatic door strikes do not assist people who cannot manipulate door handles. The design of doors is governed by AS 1428 which concerns access for people who have disabilities.

Locking people in is a form of restraint. It is only lawful when it is the least restrictive means of preventing injury to persons or persistent damage to property and it is appropriately documented and reviewed (s.44 IDPSAct). Your Worship has heard evidence about the process of dealing with challenging behaviours, the documentation of this in the person's GSP and IPP and the possible intervention of BIST.

The use of restraint must be particularised to individuals. The practice of applying restraint to groups of people inevitably means that some persons are unnecessarily and unlawfully restrained. In Kew this had unforeseen consequences regarding evacuation of residents by themselves or by staff.

VLS is not opposed to door strikes where they add safety. However it is a technological intervention which may legitimise a technological response to an individual's challenging behaviour when there may other less restrictive ways of managing that behaviour tailored to the needs of the individual. VLS supports the recommendation of KPA calling for a review of locked units.

KPA 7. Egress to BCA standards.

KPA 9. Automatic door unlocking devices connected to the fire detection system should be installed at each of the egress doors of the residential units.

KPA 21 The practice of locking all external and some internal doors at night should be further examined and reviewed to ensure the least restrictive approach for clients is adopted and that client evacuation is not compromised. A review of locked units generally must occur in relation to both doors and windows. This review should be conducted with consultation from the Parent's Association, the Community Visitors and the Public Advocates Office.

KPA 22 Each night staff member should carry a single master key at all times capable of opening all internal connecting, passage and external doors in all units. As foreshadowed by Ms McCartin, we understand that KRS will be moving to a single key system by June.

KPA 23 Every unit should have major exit doors with locks which automatically release when fire breaks out.

KPA 24 Illuminated exit lights and night lights should denote evacuation routes and assembly areas and MFB input should be obtained regarding the adequacy of such lighting.

KPA 37 KRS should adopt emergency evacuation procedures in accordance with AS3745.

MFB 7 If clients must be housed in locked premises then the doors must be fitted with automatic unlatching devices to provide ease of escape in a fire emergency.

MFB 20 As part of the continuing upgrade of the fire safety system at KRS every unit at KRS must have a primary and secondary evacuation point, marked by a beacon.

MFB 22 All doors at KRS and similar institutions should be keyed with a single key.

OPA (1k) The structure of residences should optimise the degree of ingress and egress practicable for residents, particularly in circumstances of emergency, such as the need for urgent evacuation, taking into account the fact that residents are both voluntary occupants and persons in need of care.

OPA (2g) A masterkey system should exist in all residences for windows and doors.

OPA (2h) Automatic door strikes, operated by instigation of smoke detectors, should operate in all residences to enable speedy evacuation in circumstances of emergency.

WOR 4.9 Automatic door release mechanisms should be installed. These could be activated by the alarm system or, if this was prone to abuse, by a secure manual release point on the outside of the building in alarm.

2.A.5 Institutions / training centres in general

KPA 19. Building certifiers should be provided with a full written brief by DHS regarding any renovation work conducted on the subject building within the previous five years and all other relevant information regarding prospective occupancy of the building.

OPA (1m) Residences should be designed so as to enable proximity of carers to residents, consistent with the potential needs of residents in circumstances of emergency, and consistent with the residents' entitlement to privacy.

2.A.5.1 Kew

In this sub-category there is a grab-bag of recommendations concerning the physical surroundings at Kew itself.

VLS does not consider that Kew requires a further audit. There must be an overwhelming awareness of the issues facing Kew after the previous audits and the Inquest process.

VLS submits that the recommendations underline the need to co-ordinate so many aspects of a fire safety system in an institution the size of Kew. VLS recommendations emphasize the need to make things smaller.

KPA 1. KRS to be the subject of a further fire audit and risk assessment.

KPA 8. Elimination of dead ends in accordance with the risk assessment (see point 1).

KPA 11 Unit 7/8 is a continuing fire risk. Insufficient sprinkerling and lack of an external fire escape should be addressed immediately and interim measures including extra staff should be adopted.

KPA 15 No building or renovation should be undertaken at KRS without first obtaining appropriate building permits.

KPA 16 All certified works to be inspected for compliance with certified plans prior to occupancy.

KPA 17 Design prior to construction should involve a full fire risk analysis and such analysis should involve consultation with the MFB.

KPA 18 The Building Control Commission should be encouraged to audit the existing buildings at KRS for compliance with the BCA.

KPA 60 The Parents' Association is very disturbed by the fact that Jonkar Pty Ltd has recently "upgraded" unit 24, has been considered for unit 23 and is responsible for the ongoing maintenance of unit 24. Concerns relate to the competence of Jonkar Pty Ltd generally as well as the problems which may arise from having dual maintenance contractors on the site and often operating from the one fire panel.

VLS 10 The site at KRS be renovated to ensure that the risk minimisation features noted above[2] obtain, to the greatest extent possible, for those residents who remain there. Specifically, this will entail:

- drastically reduced numbers of residents per Unit
- renovations of Units to ensure that:
  - bedrooms and living areas are of a size and configuration typical of what would be found in the community generally, with particular emphasis on issues of ease of flow and space
  - all doors are able to be opened from inside
  - windows can be opened and are unshuttered

2.A.6 Community Residential Units.

VLS submits that recommendations applicable to institutional settings not be transposed to Community Residential Units as a matter of course. Recommendations targeted at "residential facilities" must be evaluated in each particular setting before application.
We note that no recommendations were made specific to Community Residential Units.

2.B HUMAN RESOURCES

2.B.1 Management

2.B.1.1 Management within Government

MFB 30 The government, and in particular DHS, must develop a procedure for the regular monitoring and auditing of fire maintenance contractors. The MFB and the BSA should be involved in this process.

MFB 40 That all government instrumentalities and public authorities be bound by the technical, administrative and future amendments of the Building Act and the Building Regulations.

MFB 42 The state of Victoria, together with the fire protection industry and the MFB must produce a policy document outlining the requirements of various types of fire audits and fire reports expected from consultants engaged by government departments and public authorities.

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2 Refers to p 76 of VLS submissions of 7/6/97, that is: that the physical environment will be one which:

- is uncramped by its configurations and furnishings, allowing easy movement throughout the building and, when necessary, evacuation from it;
- is uncrowded, allowing residents to have their own room;
- provides numerous points of egress, including both doors and windows which be easily opened in the event of an emergency.

ULA GB 4[3] All Government buildings should be subjected compulsorily to a fire safety audit within a specified time frame. In this regard, the efforts of the Office of Building are strongly supported.

ULA GB 5 A program of mandatory ongoing inspections of Government buildings by qualified and experienced fire engineers and surveyors should be instituted.

ULA GB 6 The highest priority and urgency should be given by Treasury to the implementation of fire safety upgrade recommendations arising from fire safety audits.

ULA GB 7 A systematic program should be instituted to upgrade all Government buildings so that they comply with the Building Code of Australia

ULA GB 8 A streamlined approval and funding process should be adopted to fast track "Immediate" or "Urgent" projects desirably by Ministerial initiative to ensure the prompt and effective fire safety upgrade of Government buildings.

ULA GB 9 Senior management should be held accountable and must take responsibility for the preparation and implementation of facilities master plans and for the fire safety condition and fire safety upgrade priority given to Government buildings.

ULA GB 10 The Office of Building (or Departments and authorities as appropriate) should be required to raise and maintain a computerised fire safety compliance register listing in relation to all Government buildings relevant building details, including classification, salient history, fire safety audit details, and outstanding non-compliances, requirements and works.

ULA GB 11 All necessary regulatory changes should be implemented to achieve the above recommendations.

ULA BP 1[4] Training should be conducted as to the implications for Government building managers as to the implications for them of the Building (Further Amendment) Bill 1997. In particular, in seeking building permits for Government buildings, it will now be necessary (as with private building work) to make application for building permits in the prescribed form; to provide building practitioners in writing with all prescribed or necessary information and to be responsive to their requests for information including for example:

- class of building
- past use of building
- proposed use of building
- number of persons likely to occupy building
- extent of works proposed
- fire safety measures proposed
- a plan clearly showing the layout dimensions of any existing building and the extent of proposed works
- details of all building works over the past 3 years

ULA BP 2 Occupancy permits will now become mandatory as will the conduct of inspections.

ULA M 1 An accreditation scheme for Government building fire system maintenance contractors should be introduced.

ULA M 2. Government building fire system maintenance contracts should be awarded only to accredited maintenance contractors.

ULA M 3 Maintenance contractors will remain accredited only if they operate a quality assurance system with proper record keeping and work procedures.

ULA M 4 Accredited maintenance contractors are required at all times to adhere to Australian standard AS 1850, and will be subjected to periodic quality audits by the accreditation authority.

3 In ULA numbering, the letters "GB" refer to "Government Buildings".

4 In ULA numbering, the letters "BP" refer to "Building Permit Applications and Procedures".

2.B.1.2 Management within Department of Human Services

The thrust of recommendations in this sub-category is to ensure that facilities in the care of the Department are assessed in terms of fire safety. The concern is to obtain relevant data, to respond to dangers and inadequacies in the short term and finally to ensure an ongoing monitoring of facilities.

The recommendations range from discussion of outcomes to establishment of particular management structures to deal with issues.

KPA 19 Building certifiers should be provided with a full written brief by DHS regarding any renovation work conducted on the subject building within the previous five years and all other relevant information regarding prospective occupancy of the building.

KPA 20 DHS should report to Parliament in accordance with the guidelines 5 of the Ministerial Guidelines of 1994.

KPA 35 A central unit should be created from within DHS to coordinate fire risk awareness in residential facilities throughout Victoria and to develop training materials which staff could use.

KPA 57 DHS should investigate whether the person appointed to conduct the future fire audit of KRS should also be invited to conduct a general audit of other DHS facilities.

KPA 58 DHS should investigate the feasibility of contracting a fire safety engineer for all DHS facilities to provide expert assistance on fire engineering issues (including maintenance practices) on an ongoing basis.

KPA 61 A process for DHS to maintain a register of approved consultants for minor and major works should be developed.

KPA 62 All consultants should be provided with all relevant reports and information to ensure they are able to perform their specified function.

KPA 63 In relation to all coronial inquests (and specifically the Kew Cottages Coronial Inquest), DHS should establish a formal structure to:

(a) consider the Coroner's findings;

(b) implement the Coroner's recommendations; and

(c) monitor progress in relation to implementation of recommendations.

KPA 64 Systems must be established to ensure the smooth transfer of knowledge and information and the continuation of operational functioning notwithstanding staff and management turnover.

MFB 11 DHS should set up a consultative task-force to review emergency and fire safety procedures at all Department residences and facilities.

MFB 23 DHS must set up a task force to approach the issue of appropriate staff-client ratios and to report within 12 months.

MFB 35 The DHS must ensure that a full fire audit is carried out at all residential care facilities within the next 12 months and audited annually thereafter.

MFB 36 The MFB should be considered as a suitable long term auditor of Department fire systems in various institutions and facilities.

MFB 45 DHS must appoint a State Fire Safety Officer.

OPA (3c) Lines of responsibility for expeditious and sufficient upgrading of safety procedures and facilities at all residences housing people with intellectual disabilities should be clearly and simply specified.

OPA (4a) A working group, consisting of representatives from the Department of Human Services, the Building Services Agency, Kew Residential Services, the Kew Parents' Association and the Office of the Public Advocate, should be established immediately to plan and implement the safe housing of people with intellectual disabilities in the care of the Department of Human Services.

VLS 11 The Department appoint a person in head office who is responsible for fire safety in residential services for people who have an intellectual disability.

This person should have sufficient seniority to make budget allocations up to those amounts before which Ministerial or Cabinet approval must be sought.

This person should be responsible for:

- ensuring that residential services are allocated sufficient funds to conduct regular fire safety audits;
- ensuring that a standard form system for grading and prioritising fire risk is developed, and regularly reviewed;
- ensuring that a standard risk response action plan format is developed and regularly reviewed;

A risk response action plan must include:

- a grading as to priority;
- measures necessary to address the risk;
- a cost estimate;
- an outline of interim measures including recommendations in relation to additional staffing, re-location of residents, warnings and/or notification to key players of the risk;
- a time framework for review and endorsement of the plan and completion of measures necessary to address the risk;
- reviewing and endorsing risk response action plans;
- ensuring that funds are allocated to services to implement risk response action plans or interim measures;
- seeking Ministerial or Cabinet approval for allocation of funds, where funds involved exceed his or her authority.

These responsibilities should not be able to be delegated.

HACSU 3.1 HACSU and staff must be consulted during the course of any fire audit.

HACSU 3.2 All reports which touch upon the occupational health and safety of staff, in particular the contents of any fire audit reports, must be provided to HACSU and staff. Staff must have a full appreciation of the risks inherent in their working environment.

MFB 12 The generic emergency procedures must be reviewed and amended for each institution. The MFB should be represented on the task-force to design emergency and fire safety procedures for Dept. residences.

MFB 14 The Chief Fire Safety Warden at each residence or facility must maintain a training log.

MFB 21 Each unit at KRS must have an Emergency Information Locker. The MFB should assist the DHS in designing and manufacturing Emergency Information Lockers for KRS and similar institutions.

MFB 46 Every Department residence or facility must appoint fire wardens for appropriate areas and a Chief Fire Safety Warden for the entire residence or facility. The Chief Fire Safety Warden shall serve on the local Fire Safety Committee.

MFB 47 DHS must set up a task-force to design a programme to educate Chief Fire Safety Wardens as to their responsibilities. All Chief Fire Safety Wardens must receive this training before commencing in this position.

MFB 48 DHS must appoint a Fire Safety Committee at every Department residence or facility, which should include Class 1b occupancies. An appropriate Fire Service Officer should serve on that committee. The committee, must be appointed and meet at least once in the next 6 months. The Fire Safety Committee will be charged with the responsibility of amending the generic emergency procedures (see above) for their institution and shall assist the State Fire Safety Officer in disseminating fire safety information. Once the emergency procedures have been drawn up, the Committee must meet at least once every 6 months. They must produce a report every 6 months to be distributed to the State Fire Safety Officer and the appropriate fire service.

MFB 49 DHS must appoint a committee to look at the appropriate design of buildings for Department residential buildings. This should be a consultative approach with appropriate experts in issues such as fire prevention and risk management. A report must be produced within 12 months outlining detail of appropriate life safety levels.

VLS 7 The Department develop strategies that will bridge the oral and written culture to ensure the actual dissemination of information ensuring real outcomes rather than a paper accountability of dissemination of information.

2.B.1.3 Management within Institutions & Community Residential Units

The recommendations in this section cover:

- consultation with staff over fire issues and occupational health and safety issues;
- staff training;
- consultation with MFB;
- management structure;
- design of buildings
- staff familiarity with clients;
- evacuation protocols;
- auditing and monitoring;

VLS submits that while the recommendations have a general quality, they must be particular in implementation. Again VLS is concerned about the application of institutional practices in Community Residential Units.

OPA (1h) Safety measures should be developed in conjunction with the Metropolitan Fire Brigade for individual residences in such a way as to maximise the independence, autonomy and flexibility of residents.

OPA (1j) Safety programmes should be developed in such a way as to minimise the potential for miscommunication and human error arising out of unnecessary complexity and inaction arising out of ambiguous allocation of responsibility.

OPA (1q) Efforts should be made to optimise the continuity of care of residents, in recognition of the fact that carers accustomed to working the residents well-known to them are more likely to be attuned to developing circumstances of risk and danger.

OPA (1r) Evacuation protocols should be designed for each residence in a way that is tailored to the needs and level of disability of residents.

OPA (1s) Safety programs, including evacuation protocols, for residences should be designed in consultation with residents, carers, management, the Metropolitan Fire Brigade and other relevant agencies.

OPA (3a) Sufficient auditing and monitoring processes, at regular intervals, should be employed to ensure that staffing levels are sufficient for residents' safety and that appropriate safety technologies have been installed in residences.

VLS 12 The manager on location of any residential service for people who have an intellectual disability be made responsible for the fire safety system in place. This means the manager is responsible for:

- reporting directly to the person in head office on all matters related to fire safety;
- ensuring that fire safety audits are conducted on a regular basis, at least annually;
- ensuring that any risk response action plan is prepared in response to any risks identified through the audit process;
- ensuring that any risk response action plan with budgetary allocations which exceed his or her authority is forwarded to the person in head office identified above [See VLS 9];

- following up and implementing any risk response action plan, including interim measures detailed in the plan;
- ensuring that the fire hardware system is regularly maintained. Maintenance intervals should be consistent with the manufacturer's recommendation in relation to the specific fire safety hardware in place;
- if maintenance contractors are involved, ensuring that the contractor's performance under the contract is satisfactory, and regularly reviewed;
- if other contractors or consultants are involved in upgrading the fire safety system, ensuring that the contractor's performance under the contract is satisfactory and regularly reviewed;
- ensuring that the residence or units in the residence have an evacuation plan which identifies any special needs of the residents;
- ensuring that evacuation plans are trialed and reviewed regularly;
- ensuring that evacuation plans are reviewed in response to any changes particularly changes in the condition or profile of residents, changes to staff or changes to the internal configuration of buildings or units;
- ensuring that residents are provided with the opportunity to learn about fire safety including evacuation procedures, self rescue and safety of others;
- ensuring that staff, particularly direct care staff, have an appreciation of fire safety issues and risk management which they incorporate in their daily work. This includes ensuring that staff have appropriate training in fire safety and that the staff appraisal process assesses their understanding of risk management, including fire safety issues;
- ensuring that effective communcation systems are in place which disseminate information about fire hazards, including residents who may be a risk of fire lighting behaviour, or who exhibit fire lighting behaviour;
- ensuring that appropriate individualised responses to residents who may be a risk of fire lighting behaviour, or who exhibit fire lighting behaviour are implemented;
- ensuring that where any capital works, modifications or renovations are contemplated, plans address the fire safety system and identify any fire risk asociation with the works;

These responsibilities should not be able to be delegated.

This recommendation should apply to all managers irrespective of the number of residents in the service.

2.B.1.3.1 Management within Kew Residential Services.

The recommendations in this sub-category are in direct response to the fire at Kew. The thrust is to localise responsibility for fire safety at Kew in a management structure which has an overall appreciation of fire issues, both technical and human resource issues.

There are some recommendations which call for direct and immediate action from Kew management such as the monitoring of the fire indicator panel and improvements in the buddy system.

KPA 27 The AHCOT team's duties and responsibilities should be reviewed in consultation with staff, HACSU and the Parents' Association to ensure sufficient staff are present for emergency situations at any time. It should be anticipated that newly installed alarm systems may present teething problems over the next 12 months. During that period the administration building and fire panel should continue to be manned at all times

KPA 32 A Chief Fire Warden (answerable to the CEO) should be responsible for all aspects (physical and human) relating to fires and emergencies, fire prevention and policy development at KRS. Safety training and evaluation of fire systems would be amongst the tasks of this position with regular consultation with management and a fire committee.

It is acknowledged that since the fire Ms McCartin has assumed overall responsibility for all aspects of fire prevention, both facilities and direct care, and that her deputy may have a portfolio similar to the Fire Warden position described above.

KPA 33 A fire committee is necessary with personnel from the facilities and direct care streams and input from all levels of staff, management, AHCOT and the Parent's Association. It is acknowledged that the Fire Safety Committee at KRS has been reconvened and it is hoped that the committee will address all risk management issues including fire incidents or near misses at KRS, appropriateness of evacuation plans, publication of fire alert bulletins, submissions to management and AHCOT regarding staffing adequacy, funding submissions and matters raised by the KRS MFB Liaison Committee and the Parents' Association.

KPA 34 A greater degree of access to information as to renovations and fire prevention measures should be provided to the Parents' Association for discussion at liaison meetings. Parents should be represented on the Fire Committee. There should be ongoing and continuous participation of the Parents' Association in the management process at KRS.

The Parents Association should have access to all health and safety reports for KRS.

KPA 36 It is acknowledged that greater liaison will occur between the MFB and KRS regarding fire training and fire awareness. We hope this will be an enduring process with regular MFB audits of individual units.

KPA 39 The full range of modern training techniques for group and individual instruction must be examined, including lectures, films, videos, drills, computer modelling and group discussion. We note that fire response issues are currently being addressed to some degree.

MFB 19 The "buddy system" mechanism at KRS must be changed as a matter of urgency so that the nearest units respond to an alarm.

MFB 24 Any changes in the staff or client make-up of a unit at KRS must be advised to the Chief Fire Safety Warden for the consideration of the fire safety implications of such a change.

VLS 1 That until a technical solution is found [to the issue of each local unit identification of which detector has gone into alarm] the Department should ensure that the fire indicator panel is constantly monitored by a staff member.

2.B.2 Staff

2.B.2.1 Staffing levels

The basic principle is that there be sufficient staff to meet the changing needs of individual clients and who can provide continuity of care.

HACSU 1.1 There should be a comprehensive review of staff/client ratios undertaken, in consultation with HACSU, KRS management, the Parent's Association, the MFB, and the fire detection and prevention contractors at KRS, to properly assess current staff needs, in the context of the present fire detection and prevention system.

HACSU 1.2 Such a review should be on a unit by unit basis, taking into account, inter alia, the

a) number and gender of clients in the relevant unit

b) type and level of intellectual/psychiatric/physical disability

c) range and gravity of challenging behaviour, in particular the risk to self, other clients and staff

d) type of program and level of staff management required

e) physical layout and environment of the unit

f) equipment and disability aids available to staff

g) existing fire detection and prevention system

h) capacity to evacuate clients before conditions become untenable (i.e. in a matter of minutes) before buddies and/or the After Hours Coordination Team (AHCOT) may arrive to lend assistance

i) classification of staff

HACSU 1.3 Pending such a review there should be

a) an immediate increase in night duty staff

b) a reversal of the policy of amalgamation of units to the extent that two Deputy Unit Managers are employed per unit

HACSU 1.6 In view of the reduced staff numbers at night, all night duty staff must at least have the classification of Intellectual Disability Service Officer.

KPA 25 The present system of one unit manager attempting to manage double units should be abandoned. No unit should exceed 20 clients and each unit must have a unit manager at MRN3 level.

KPA 26 The number of carers on duty in units during after hours periods should be increased, not only to cope with emergencies but also to ensure tighter checking and closer supervision of residents. Ratios should take into account resident's differing degrees of disability and special needs, such as challenging behaviour.

Where any unit is divided into flats, it will be appropriate to have one carer per flat during the evening hours when clients may still be expected to be awake.

KPA 29 A consultative working party should be established to determine appropriate needs-based staffing levels on a unit by unit basis for day and night periods. Each unit should be assessed and such assessment should address minimum staff levels and minimum staff qualifications by way of a complete unit profile to be adhered to at all times.

KRS staff, HACSU, the Parents' Association, Community Visitors and the Public Advocates Office should all be consulted for input into this process. The Consultation process should also address the availability of in-service training for KRS staff and should provide incentives for staff to undertake that training. Other issues to be addressed include handover, sleep over, use of casual staff, minimum qualifications for AHCOT, English language proficiency and the impact on staff capacity to supervise clients of non-direct care chores such as laundry and unit based cooking etc.

OPA (1n) Sufficient staff should be rostered, both during the day and at night, to respond adequately to individual residents in face of a threat to safety or an emergency.

2.B.2.2 Training

HACSU 2.1 All direct care staff at KRS should receive appropriate training in the specialty field of intellectual disability. Human Service Workers should be required to undergo the Advanced Certificate in Residential and Community Services (Intellectual Disability) or have an equivalent qualification.

HACSU 2.2 All staff should receive training in the identification and management of clients who pose a fire risk.

HACSU 2.3 Adequate replacement staff must be made available to permit staff to attend study or training.

HACSU 2.4 All new staff must have a comprehensive induction and orientation.

HACSU 2.6 As staff may be called to attend an emergency in another unit at any time, each staff member must have an up to date knowledge of the physical layout of all units, and the appropriate fire evacuation procedures for each unit.

KPA 30 A specified minimum standard of induction should be performed prior to any staff commencing duty in a direct care role.

KPA 31 Strategies to reduce staff turnover should also be considered. Bearing in mind staff turnover, no staff member should be employed in a direct care role until they have been fully oriented.

KPA 38 A comprehensive training program, should be instituted in collaboration with the Metropolitan Fire Brigade so that all staff caring for residents become proficient in the theory and practice of fire safety and evacuation procedures.

KPA 40 Every member of a buddy unit should be informed thoroughly as to client behaviours, client identification and the geographic layout of adjacent units (including regular tours). Every unit should be manned at night by at least one staff member who has received fire warden training. We understand that there is now a greater degree of buddy orientation provided and this should continue.

KPA 41 Consideration should also be given to offering special incentives to undergo additional training.

KPA 42 Fire drills and evacuations should be carried out regularly day and night. Every direct care staff member should participate. The MFB should be asked to observe such drills on a regular basis and records of all drills should be maintained.

KPA 43 A specified appropriate minimum standard of orientation in fire safety should be required before staff commence duty.

KPA 46 Staff should have fire risk awareness training and be trained in controlling the use by clients of cigarette lighters and matches. Staff should also be provided with and trained in the use of fire safety equipment including hydrants and hoses. Such fire safety equipment should also be the subject of regular safety audits.

KPA 47 Strategies should be implemented to cope with fire-lighting behaviour and other types of challenging behaviour likely to endanger other people.

MFB 4 The DHS must ensure that all relevant staff at KRS have a full and operational knowledge of the addressable mimic panels at units and the main panel at the administration centre.

MFB 13 All staff must receive training in the emergency and fire safety procedures relative to their level in their institution or facility.

MFB 15 All new staff or staff that are new to an institution or facility must undertake the training as a compulsory part of their induction program.

MFB 17 DHS must ensure that all staff with low English language proficiency have adequate access to emergency procedures.

MFB 18 DHS must ensure that appropriate training time is allocated to fire safety training.

MFB 26 All staff at KRS must be trained in risk management, to a level commensurate with their responsibilities. An approved risk management model such as FEMA should be used.

MFB 27 All DHS direct care staff should be made aware of the MFB/CFA Juvenile Fire Awareness and Intervention Programme. They should be encouraged to refer suspected or actual firelighters or those with fire risk behaviour.

OPA (1e) Sufficient, individually tailored training should be provided to staff to enable them to maximise the independence, autonomy and flexibility of residents in respect of general life skills, which would equip them to respond safely in relation to safety issues and particularly in the context of an emergency.

OPA (1j) Safety programmes should be developed in such a way as to minimise the potential for miscommunication and human error arising out of unnecessary complexity and inaction arising out of ambiguous allocation of responsibility.

OPA (1o) Staff should be trained sufficiently to respond to residents in circumstances of emergency.

OPA (1t) Evacuation procedures should be practised at regular intervals, both at times during the day and at night, so that both staff and residents optimise the capacity of staff and residents to evacuate a residence in circumstances of emergency.

OPA (1u) Staff should receive regular (at least six monthly) training in emergency procedures and the use of first response fire equipment.

VLS 2 That all staff receive regular instruction and familiarisation with the fire detection system. In the induction of new staff there must be training and familiarisation.

WOR 4.6 All staff at KRS who may have to use the main FIP should be fully trained in its operation and there should be regular refresher courses to ensure this proficiency is maintained. In particular, staff at the administration building must be fully conversant with the procedure for identifying the detector and room which is in alarm. The staff member pushes the alarm acknowledgement button once to acknowledge the alarm. He or she then pushes the 'point' button a second time to show the number of

the detector in alarm and then identifies the room location by reference to the map at the main FIP. This information should be given to staff in the building in alarm to speed evacuation from the affected area and to the MFB while in transit to allow it to proceed directly to the room in alarm.

2.B.2.3 Dissemination of information between staff and between staff and management

Staff cannot make an assessment of risk unless they have an appreciation of the particular risks associated with the facility where they are working. For example the staff at Kew would have been more vigilant about fire issues if they had been aware that they were working in a death trap if a fire were to occur.

VLS does not support 12 hour shifts for direct care staff, and submit that staff are too tired towards the end of these shifts to enable adequate attention to their duties and an adequate handover.

HACSU 1.4 Full 12 hour day and night shift hours should be maintained, with the most skilled and experienced staff member (i.e. the Deputy Unit Manager) participating in the shift handover. Handover times must be increased to enable night duty staff to fully appreciate any identified risk factors which may impact upon the health and safety of staff and/or clients over night.

HACSU 1.5 Only active (i.e. non-sleeping) staff should be on night duty at all times. They must be able to concentrate on direct care duties, in particular the supervision, monitoring, documentation and reporting of risk behaviour. Sufficient time must be allotted for comprehensive handover to day staff, so as to ensure that communication regarding client needs and risk behaviour is at an optimum and safe level, for the full 24 hour period, seven day per week.

HACSU 2.5 Sufficient staff resources must be made available to enable all direct car staff to fully familiarise themselves with the contents of client files. Familiarisation and regular review must be carried out in a systematic way, to take account of staff rosters, transfers of staff or clients between units, and changes in staff due to holiday, sickness or turnover.

KPA 28 Handover time between shifts should be 30 minutes.

KPA 29 A consultative working party should be established to determine appropriate needs-based staffing levels on a unit by unit basis for day and night periods. Each unit should be assessed and such assessment should address minimum staff levels and minimum staff qualifications by way of a complete unit profile to be adhered to at all times.

KRS staff, HACSU, the Parents' Association, Community Visitors and the Public Advocates Office should all be consulted for input into this process. The Consultation process should also address the availability of in-service training for KRS staff and should provide incentives for staff to undertake that training. Other issues to be addressed include handover, sleep over, use of casual staff, minimum qualifications for AHCOT, English language proficiency and the impact on staff capacity to supervise clients of non-direct care chores such as laundry and unit based cooking etc.

KPA 44 Several copies of client and client profile lists should be placed in various selected places around the Units (office, each flat and in an external fire box on the wall of the building) so that lists are easily accessible.

KPA 45 It is acknowledged that improvements have been made to enable clients to be more quickly identified and accounted for in the case of an emergency evacuation. This practice should continue.

KPA 48 All direct care staff should be required to be informed of the relevant portions of GSPs, IPPs and client profiles of all residents in their charge and to implement recommendations contained therein.

KPA 49 Direct care staff should be required to identify to their line supervisor potential fire lighting or fire risk behaviour.

KPA 50 Each unit manager should be required to identify all clients with any past or present fire lighting or fire risk behaviours or propensities.

KPA 51 Hard Copy client profiles with a photo and all relevant alerts should be made easily accessible and compulsorily read by all staff.

MFB 16 Every unit at KRS must have a short booklet provided to all staff and available for all temporary staff to inform them of the basic procedures for that unit

MFB 28 A simple system of noting client alerts must be used so that staff can access this information easily. Alerts should not be graded but simply notify the staff member of a risk, rather than the frequency or severity of the behaviour. The current move at KRS to access all client alerts on unit computers should continue.

OPA (1f) Sufficient information should be formally recorded by carers in relation to any particular dangers posed by residents so that such matters can be responded to promptly, appropriately and safely.

OPA (1g) Sufficient pertinent information about the current needs of particular residents and any safety issues arising out of recent incidents or behaviours should be provided during "handover" times between carers' shifts.

OPA (1p) Hard copy resident profiles, accompanied by a reasonably recent photograph, together with relevant alerts, should be made easily accessible and read as a matter of standard procedure by any carers dealing with residents.

2.B.3 Clients

There are two issues involved in these recommendations. The first is the empowerment of clients to protect themselves when faced with fire and how to achieve this empowerment. We endorse these recommendations.

The second relates to the needs of clients with challenging behaviours where these behaviours involve fire risk activity. VLS reiterates that challenging behaviours must be dealt with individually and the degree to which a behaviour will be a real risk will also depend on the safety of the environment.

MFB 25. The categorisation of the behaviour of a client in a particular category should not be allowed to obscure the true nature and degree of the fire risk presented by that behaviour.

OPA (1c) Maximum opportunity should be afforded to residents to optimise their own safety and to learn protective behaviours.

OPA (1d) Care for the residents should be provided so as to maximise the independence, autonomy and flexibility of residents so as to equip them to respond safely in relation to safety issues and particularly in the context of an emergency.

OPA (1i) Safety programmes should be developed in a way which is adapted to the particular behaviours, histories and disabilities of residents.

2.C FIRE PROTECTION INDUSTRY

MFB 5 The MFB should continue with its aim to reduce response times to alarms of fire. The Brigade should be commended on the 1996/97 goal of achieving response times of 7.7 minutes in 90% of cases. It should be acknowledged that the Brigade's prompt response to the fire at Unit 30/31 saved lives.

MFB 41 The Fire Protection Industry must change their philosophy in relation to interim systems. Whilst acknowledging that it is the responsibility of fire engineers to develop appropriate interim systems, it seems that there is a consensus view among fire engineers that the interim systems must comply to standards or be elaborate in nature. This is not the point - interim systems are there to provide short term corrective measures for otherwise deficient systems and may comprise of simple measures. They are not meant to bring systems up to standards - a full fire upgrade may be necessary for that. A discussion paper on the role of interim or corrective measures should be developed (the Fire Services should have input into the development of such a document) so as to spark [interesting choice of metaphor! - VLS] industry discussion as to the development of the interim measures philosophy.

MFB 42 The state of Victoria, together with the fire protection industry and the MFB must produce a policy document outlining the requirements of various types of fire audits and fire reports expected from consultants engaged by government departments and public authorities.

MFB 43 AS 1851.8 must be extended to include the testing of the sensitivity of detectors. The MFB should be consulted in relation to these changes.

MFB44 AS 1603.1 of 1997 and 1603.2 of 1987 must be amended to include appropriate mechanisms for preventing impact damage to detectors, such as the compulsory use of sensor guards in risky locations. Such sensor guards must be of the type that do not interfere with the sensitivity of the detectors.

Purchasers must receive information and warnings about the risks that impact damage may have on detectors and the necessity of implementing regular testing and preventative mechanisms.

2.D BUILDING INDUSTRY

VLS recognises that the Building Code of Australia may need to take account of the special needs of persons who have disabilities, even in relation to class 1a buildings. VLS submits that any changes to the Building Code of Australia take into account the need to maintain a homelike environment consistent with community norms and values.

MFB 37 The Building Code of Australia must be reviewed to include buildings that house the intellectually disabled, but are not hospitals. A consultative approach involving experts in the care of the intellectually disabled, fire prevention experts and risk managers must design appropriate standards for fire protection for such buildings.

MFB 38 That the following [building] regulation be adopted:

* Accommodation for the aged, disabled or children -

This regulation applies to any building which is a common place of long term or transient living for a number of unrelated persons who are aged, disabled or children.

A residential type sprinkler system complying with AS 2118.4-1994, or other equivalent fire suppression system, must be installed in the building.

Where the sprinkler system referred to in sub-regulation (2) has more than 100 heads or the building referred to in sub-regulation (1) is registered to accommodate more than 32 residents, the system must be connected to fire brigade in accordance with Building Control Commission Practice No. 7.

This regulation must be complied with-

(a) within 5 years of the date of commencement of this regulation; or

(b) at change of tenancy or management of the entire building; or

(c) at the change of ownership of the entire building -

whichever is earlier.

ULA BP 3 It should be made mandatory for building practitioners when considering building permit application to:

- inspect the file held by the relevant local municipality relating to any existing building as to which approval is sought;
- ensure that details of all applications and approvals are provided to the relevant municipality for its building files;
- physically inspect any existing building as to which application is made;
- personally inspect all buildings for which approval has been granted or confirm that another qualified building practitioner has completed interim and final inspections.

ULA FA 15 In the absence of any Australian Standard or code of practice governing the scope and methodology of the various types of fire audits, the Fire Code Reform Centre (or Standards Australia) be requested to develop an Australian Standard or code of practice for the conduct of the various types of fire audits.

ULA FA 2 The Metropolitan Fire Brigade or the national organisation of which the MFB is a member be represented and provide input to the Fire Code Reform Centre in the development of an Australian standard or code of practice for the conduct of fire audits.

5 In ULA numbering, the letters “FA” refer to “Fire Audit Standard or Guidelines”

2.E CONSCIENTISATION IN FIRE ISSUES

2.E.1.1 Government

ULA GB 1 Clause 19 of the Building (Further Amendment) Bill 1997 which extends the operation of the building permit, occupancy permit and building inspection system to Government controlled buildings be strongly endorsed.

ULA GB 2 Clause 19 be proclaimed to commence immediately.

ULA GB 3 A training, education, information and cultural change program should be instituted as soon as possible to widely inform and advise facilities and building managers and Government officers generally that private sector standards now mandatorily apply to all Government buildings

2.E.1.2 Public

The advantage of public campaigns is that they reach all members of the community, including persons who have an intellectual disability.

The introduction of "child-proof" lighters gives rise to two issues. The first is that the Bic lighters to which VLS has had access works on the principle that a child lacks the strength to operate them. Persons who have an intellectual disability are not children, but adults, and have sufficient strength to operate them.

Secondly it is discriminatory to introduce an item for sale which is designed so that it cannot be used by persons who have certain disabilities. Most people who have an intellectual disability are not a fire lighting risk and are being unjustly targeted by the introduction of this product.

VLS submits that the appropriate way to deal with any risk associated with fire lighters is on an individual basis through the GSP and IPP process.

MFB 29 The introduction of legislation to prohibit the sale of cigarette lighters not having child resistant features should be supported and a standard should be developed setting out the required characteristics of such lighters. In the interim, child resistant lighters of the kind manufactured by Bic should be made available for sale at residential care facilities.

VLS 6 There be a public advertising campaign similar to that used for road safety to elevate fire safety awareness in the community.

APPENDIX 5 BIBLIOGRAPHY

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APPENDIX 6 GLOSSARY OF ABBREVIATIONS

AHCOT	After Hours Coordination Team
BCA	Building Code of Australia
BIST	Behavioural Intervention Support Team
BSA	Building Services Agency, Department of Infrastructure
CFA	Country Fire Authority
CMB	Capital Management Branch, Department of Human Services
DFO	District Fire Officer
DHS	Department of Human Services
DPH	Department of Public Housing
DSB	Disability Services Branch
FIP	Fire Indicator Panel
FIU	Fire Investigation Unit MFB
FRAU	Fire Risk Assessment Unit
FSC	Fire Safety Committee
GSP	General Service Plan
H&CS	Health and Community Services
HSW	DHS workers
IDSO	Intellectual Disability Service Officers
IPP	Individual Program Plan
KRS	Kew Residential Services
LFF	Leading Fire Fighter, MFB
MDF	Medium Density Fibre Board
MFB	Metropolitan Fire Brigade
MRN	Mental Retardation Nurse
PCG	Project Control Group
SAH	Special Accommodation House
SO	Station Officer, MFB
SRS	Supported Residential Services
SSL	Scientific Services Laboratory
ULA	Umow Lai & Associates
VLS	Villamanta Legal Service

APPENDIX 7 ACKNOWLEDGEMENTS

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COURT NETWORK

The court wishes to acknowledge the volunteers from Court Network who assisted the families and witnesses during the inquest.

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