OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of two children at Murgon**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Murgon
FILE NO(s):	COR 2004/11 and 12
DELIVERED ON:	18 January 2010
DELIVERED AT:	Kingaroy
HEARING DATE(s):	18 & 19 February 2009
FINDINGS OF:	R Lebsanft, Acting Coroner
CATCHWORDS:	CORONERS: Inquest – child deaths, house fire, Department of Child Safety (now Department of Communities)

REPRESENTATION:

Counsel Assisting the Coroner	Mr J Tate, Crown Law
Department of Child Safety	Ms K Carmody
Family	Mr M Oliver i/b Aboriginal Legal Service

This is the finalisation of an inquest into the deaths of two children at Murgon on 25 August 2004 and it is being finalised here today at Kingaroy on the 18 January 2010. This time has been set aside for the delivery of the findings and recommendations with respect to the cause and circumstances of the deaths of these two children. An inquest into the deaths was held at the Murgon Court on the 18 and 19 February 2009. There were some other preliminary proceedings on other dates.

Section 45 of the *Coroner's Act 2003* (the Act) clearly sets out those matters which a Coroner must, if possible, establish. These are:

(1) That a death has in fact occurred;
(2) The identity of the deceased persons; and
(3) How the persons died;
(4) When the persons died;
(5) Where the persons died; and lastly
(6) What caused the persons to die.

Section 46 of the legislation provides that a Coroner may, where it is deemed appropriate, comment on matters relating to:

(1) Public health and safety;
(2) The administration of justice;
(3) Ways to prevent deaths from happening in similar circumstances in the future.

And finally on the legislative point, section 48 of the Act provides the Coroner with authority to report to appropriate bodies when they reasonably suspect that an offence has been committed or misconduct has occurred. Further provisions of the legislation preclude any findings of guilt for a criminal offence or any findings of criminal liability on the part of any person. It is always important to bear in mind when considering these matters the observations of his Honour Justice Toohey in the matter of Annetts and McCann [1990] 170 CLR 596 and following the words of Lord Lane often quoted in matters of this nature is a framework to consider the evidence put before the Court.

Lord Lane stated,

> *"It should not be forgotten that an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are not suitable for another. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial; simply an attempt to establish fact. It is an inquisitorial process, a process of investigation, unlike a trial. Although a Coronial inquiry is not a judicial proceeding in the traditional sense, the rules of natural justice and procedural fairness are applicable, the content of such rules to be applied depending on the particular facts of the case in question."*

Turning to the facts in this particular matter; the incident which brought about this inquest was a house fire at 77 Macalister Street, Murgon. The house was a high-set wooden constructed dwelling and was rented by the children's mother. Also in the house on the morning of the fire were three other children.

At approximately 6am on that morning the children's mother had arisen, turned on the oven in the stove to help heat the house. There were no other heaters in the house. This method provided warmth. The children's mother then left the house and went to the nearby Commonwealth Bank to withdraw money to enable her to buy food for breakfast. After obtaining some money she made her way to Swifty's Mobil Service Station. The service station is also in Macalister Street. This was some hundred metres from her residence. The children's mother was at the service station when she heard from a passer-by that there was a fire in a nearby house. This was, of course, her house. She immediately ran back to her house.

Murgon police officers Sergeant Gangemi and Constable Norman were on patrol that morning. They were returning to Murgon when they observed smoke rising from above shops in Macalister Street. These officers attended the scene at 77 Macalister Street. At the time of their arrival the house was well engulfed in flame. Police spoke to Levi Currie and a Scott Hensler, aside from other persons, all at the scene, and it was ascertained that three children had been saved from the house but that there were still children inside the house. By this time the flames were so intense there was no possibility of entering the dwelling.

Levi Currie was possibly one of the first on the scene. In evidence he stated, and this is directly from his testimony,

> *"It was about 6 o'clock in the morning. I got up. I had a look outside. I seen big, black smoke coming out of the house, so I just yelled out to all the other mob in the house, 'There's a fire ……. Hurry up, run, come and help me.' And I took off. I jumped the fence. I run over. I run straight up to the door. I went straight in the house. I seen the other two little kids. I grabbed them two first. I took off outside, put them down. I ran back - ran back up. I went back in. I was looking around because another was singing out, 'Get me out, Uncle, get me out.' And I tried to go through the door but it was all on fire. I tried to touch it. It was hot. So we had to go another way. I went and asked the bloke from next-door to get a chair and smash the window and get her out through the window while I go back in and look for the other two, but I couldn't find them. Too much smoke. I was choking myself, and that was all."*

Now, a Scott Hensler had been working opposite the house unloading a Queensland Rail truck. He heard glass exploding. When he arrived at the house he noticed Levi Currie standing at the fence with two other female persons. Hensler's evidence continued,

> *"I ran up the stairs, went to the front door, which was open, to try and get in. The flames were up on the ceiling and the bedroom door was left open. I went to try and get in but some of the roof fell down, so I had to move back. People were yelling, but I don't know what they were saying. I yelled because someone told me when I went through the front that there was someone in there. I don't recall the name they were saying. After looking through the door I yelled out, 'Come to the door.' A little girl's voice said, 'I can't.' I looked up to the ceiling inside the house which was on fire and down the hallway which was engulfed in flames and smoke. The flames looked like water moving across the top of the timber. I thought at the time that the work jacket I had on was not fire resistant, so I removed it and my work hat and threw them over the veranda onto the ground. I then started to look*

around while I was on the veranda and saw that there was a closed window. I yelled out to the little Aboriginal girl from the front door to go to the window. She moved the curtains so I could see she was there. I couldn't see in because there was too much smoke. I couldn't see in at all. I told her, 'Step back so I can break the window.' I picked up what must have been a wooden gate from the front of the house and hit the glass with that. The window was quartered with glass. I broke the bottom two panels and knocked out the wooden divider with my hand. I used the gate to knock out the remaining glass shards so that I could get her out. After I did this I saw her hand. Smoke was coming out through the open window. I put my head inside and then all I can remember is having my hands under her arms. I can't remember if she was facing forward or back. I dragged her out through the window and onto the veranda. I remember then looking up and seeing the ceiling above me on the veranda to be on fire. I was still holding this little girl the same way and ran down the front stairs. As I was going down the steps she grabbed hold of the railings and said, 'She's still inside.' And she said the name of the baby, but I don't remember what the name was. I pulled her hand away and continued down the stairs and I'm pretty sure I put her outside the front gate. The Aboriginal people that were there took her away and went with her. I then turned around to go back in and I stopped to look at the house and thought that I could not get back in as there was too much fire. Then a white man with glasses, blond hair and brown clothes yelled out, 'No more people going in there. It's too dangerous.' That's when I stopped, grabbed my clothes and waited until emergency services arrived."

The fire service arrived at approximately 6.23am. Fire Chief Dennis made a reconnaissance and was made aware there were persons in the house. After the reconnaissance he stated,

"The fire was at the front of the house, the full width of the veranda on the front of the house, so it was virtually impossible, in my opinion, totally impossible to enter via that means and at the side of the house. The steps at the side of the house - it was - it was a full fireball, so it was involved to such an extent that it was impossible to make entry. I considered in my own mind that if there were people in the house and the extent of the fire in the house there could be no way that they could still be alive."

In the team of four fire officers who first attended there were two persons who could have donned breathing apparatus, but the reconnaissance by Dennis ruled entry by those officers not an option due to the house being too engulfed in fire.

Ultimately the fire was extinguished, searches made and the bodies of the two children located. The scene was examined by various persons, including Senior Constable Holahan, who at that time was from the scientific section Forensic Branch at Brisbane. Holahan stated in his report:

"(1) I formed the opinion that the fire originated in the area of the hallway floor against or in close proximity to the wall dividing the third bedroom from the living room near - upon the remains of a pile of paper. The probable source of ignition was a cigarette lighter applied directly to paper on the floor of the hallway.

(2) At that point of origin there were no electrical appliances present at all. There was no wiring associated with that area nor any appliances. So it was clear from that point that we could exclude electrical cause to this fire.

(3) Samples were taken of the timber floor from the hallway and near the doorway to that bedroom. This was for the presence of accelerants. There was a negative result to the test for the presence of accelerants."

Senior Constable Holahan made the assumption that the cigarette lighter was linked in some way to the deceased. The lighter was located beneath the hole in the floor amongst the papers. They were the only source of ignition located within the premises. In his report he continued,

"As a result of my examination I formed the opinion that the fire originated on the area of the hallway floor against or in close proximity to the wall dividing the third bedroom from the living room near upon the remains of a pile of paper. The probable source of ignition was a cigarette lighter applied directly to paper on the floor of the hallway."

He continued,

"I am simply relying on my observations of the location of the two deceased children and the location of the cigarette lighter and their proximity to the area of origin of fire, preventing them from leaving the premises upon the development of that fire So I'm relying on my observations being that the children died simply by misadventure causing the fire in this case."

The family was known to the Department of Child Safety prior to the fire. As a result of this fire and the deaths of the children there was a review undertaken by the Department with some external and internal reviewers. This was pursuant to the Child Protection Act. The purpose of the review and the subsequent report was to review and outline whether the Department's involvement had complied with the legislative requirements and policy and whether that compliance and involvement was adequate and appropriate. The purpose of the review was also to comment on whether legislative requirements and the Department's policies as they related to the children were adequate.

There was a later review titled "Child Death Case Review Committee". That oversight review committee reviewed the earlier review and that review was done pursuant to the Commissioner for Children and Young People and Child Guardian Act of 2000. There was a document titled "Response to Coroner Steve Gutteridge, Murgon Magistrates Court". Mr Gutteridge was the then Coroner. It detailed just where the Department of Child Safety is today as opposed to where it was in terms of the funding and performance ability and the capability at the time of the fire in 2004.

Counsel appearing on behalf of the Department, Miss Carmody, called witnesses to explain and build on this information. The evidence of witness Matthew Lupi went to the internal review recommendations. In that review there were 10 recommendations which the Department had been advised it should implement. His evidence continued to an Oversight Committee

recommendations. He also touched on a Crime and Misconduct Commission report conducted in January 2004, pre the fire, in relation to the protection of children. He also spoke on the topic of funding to the Department. His evidence was on where the Department is now.

The inquest did not hear from the manager of the Murgon office at the time of the fire; however the manager who took over that office shortly after the fire, a Patricia Smith, gave evidence. Ms Smith spoke on what had happened in response to the 10 recommendations. And the third and final witness for the Department, a David Ponting, was the manager of the Case Review Unit, Complaints Case Review and Investigation Branch.

Now, the Child Death Case Review initially had made 10 recommendations. Two of those were involving a computer system. As the Department upgraded its computer system those two recommendations became redundant. There was a third conditional endorsement regarding an indigenous officer. The one recommendation not endorsed was a consideration for providing one single location for the area office.

Ms Smith's evidence continued that at the time of the fire the Murgon office was one which housed staff, some of whom were Youth Justice personnel and the others were Child Safety personnel. At the time of giving evidence by Ms Smith, staffing in the Child Safety office was 24.5, with 11 of those Child Safety officers. Basically half were stationed at Kingaroy and the remainder based in Murgon, with an investigation team also based in Murgon. All staff are highly trained. Training is done by a specialist training branch and there is ongoing professional development. It was noted that in some instances where training was sourced in their own community this had been able to be provided through Sunshine Coast TAFE, this service provider established following contact by the Department. It was noted financial incentives are also utilised to attract and retain staff in the centre, there having been a significant problem attracting, training and retaining staff.

Ms Smith also spoke of BACCA, the Barambah Aboriginal Child Care Agency, and the contact had by her office with that recognised entity when dealing with families. Members of BACCA are also members of the SCAN team. On the topic of team stability, I thought that Ms Smith spoke proudly, and rightly so, I must add, on the staff stability within this area. In cross-examination by Mr Tate the question was asked, *"If we look at the circumstances, the factual circumstances, the nature of the notifications, the number of notifications - this relating to the family - if that information was before you today would the Department act differently? That's on the assumption that there have been so many changes since 2004 to now. How would this case be dealt with now?"* Answer, *"It is chalk and cheese, really. I probably believe the level of intervention would have been higher."*

Mr Tate closed his cross-examination of Ms Smith with an offer to her to recommend improvements to work practices whereupon Ms Smith replied, *"I think the recommendations of the CMC inquiry - I certainly had a long history in the Department pre-CMC inquiry and probably have not quite as long a history to go in the Department post-CMC inquiry, the changes have been enormous. The Department by no means is perfect. We're a human service industry dealing in a very difficult area and I don't think perfection is going to be achievable, but I do believe that the Department of Child Safety is just very different in many, many respects to the old Department. In this, it was a very tragic accident, so in making any recommendations all I can say is that I believe that the Department is - much more professional unit now and one*

would hope that these sorts of accidents won't happen again."

The final witness introduced by Miss Carmody was a David Ponting, who was the manager of the Case Review Unit in that he is to manage the reviews of cases involving children who have died and within the three years prior to their death had been known to the Department of Child Safety. This was an internal review chaired by the Deputy Director General of the Department. A copy of the generated report was then sent for external review done by the Commission for Children. On the topic of delays and difficulties encountered in this matter and generally State-wide in getting information from the Department of Child Safety sufficient to enable a Coroner to contemplate holding an inquest, Mr Ponting said, *"I can certainly give that assurance. Sorry, just thinking forward there, just in implementing this new process there's been - that's been done in partnership with both the Premier's Department and the Commission of Children and Young People and as part of that we're implementing a new strategy about following up on all actions that should have been taken with a register which will be inspectable by the Commission as well. So I think that should keep things fairly much on track. The other, I suppose, advantage with a new system that's implemented, if you look at an old style review, both from the recommendations from the Department's review and the number of recommendations coming from the Commission, they were quite large and I suppose the - the impost, particularly when you're doing anything up to 70 reviews a year, it's quite large in that is in what is an already very busy field of child protection. With the new system, because it has moved away from that, look at absolutely everything, look at what the key service delivery issues are, I think at the end of the day we'll find less recommendations, although they're more relevant, and so actually following them up, ensuring that they've been carried out, will be a far easier task and it will now be basically an audible task."*

The deaths of these children were an obvious tragic event. The inquest has heard in full the details of the fire, of the work of police, fire brigade, other service agencies and private individuals on that morning in bringing the fire under control. Documentary evidence was presented to this inquest and also documentary evidence which was not formally received into evidence is considerable, and Professor Bob Loni has been the author of some of that material.

The Department of Child Safety came under the microscope and it would seem that either in part or as a direct result of this incident there have been far and wide improvements in the mechanics of the manner in which the Department of Child Safety operates. As a result of the oral and written testimony before the inquest I am satisfied that the Department have taken those necessary steps to address shortfalls which were evident in their service delivery at the time of these deaths. I do not propose making any further recommendations regarding the ongoing operation of and the service delivery of this department.

Some may say that the Department of Child Safety has too much power, whilst other persons may argue that it still does not have sufficient authority to carry out its duties. I do not intend addressing those topics.

In closing this inquest, it would be derelict of me if I did not make a recommendation that both Levi Currie and Scott Hensler be nominated for bravery awards in recognition of the totally unselfish manner in which they both risked their lives to rescue the young children. I have no doubt that if it were not for those two gentlemen and their actions, then this inquest would

have been investigating a greater number of deaths.

And lastly, I wish to place on record my thanks to the children's mother and grandmother and members of the family and various other support persons who have attended this inquest.

Pursuant to section 45 of the *Coroners Act 2003* I make the following findings:

The two children:

(1) died as a result of smoke inhalation;

(2) died on the 25th of August 2004;

(3) died at 77 Macalister Street, Murgon; and finally

(4) died as a result of being trapped in a house fire and being overcome by smoke and as a result of the very real and present danger to persons at the fire scene who were attempting to rescue the children, were then unable to be located and rescued before they perished.

I thank all parties for their presence here today and there being no further matters, I formally close this inquest.

R. Lebsanft
Acting Coroner
Kingaroy
18 January 2010