CORONERS COURT
NEW SOUTH WALES

Inquest:	**Inquest into the deaths of:** Urbana ALIPIO Doris Mercy BECKE Lola Joyce BENNETT Emmanuela CACHIA Caesar GALEA Reginald Joseph GREEN Joan JOY Esther NEWHAM Alma SMITH Dorothy STERLING Neeltje VALKAY Verna Noeleen WEBECK Ella WOOD Dorothy WU
Inquiry:	**Fire at Quakers Hill Nursing Home, Hambledon Rd, Quakers Hill**
Hearing dates:	8-12 September; 29 September – 1 October 2014
Date of findings:	9 March 2015
Place of findings:	State Coroner's Court, Glebe
Findings of:	**Deputy State Coroner H.C.B. Dillon**

Catchwords:	**CORONERS – Joint inquests and fire inquiry –** Multiple deaths by fire and smoke inhalation – Deliberately lit fire in nursing home – Drug-dependent nurse stealing drugs – Lights fire to destroy evidence – How nurse employed – Whether nurse should have been suspended before fire – Whether fire safety standards met – Whether design standards sufficient – Response and performance by fire fighters – Heroism of fire fighters, nursing staff and police officers – Lessons learned -- Recommendations
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Representation:	Ms K Stern SC with Mr C McGorey (Counsel Assisting) instructed by Ms J Murty (Crown Solicitor's Office) Mr M Spartalis instructed by Ms K Dobbie (McCabe Lawyers) for NSW Fire & Rescue Service Mr B Hodgkinson SC with Ms W Thompson instructed by Ms J Makris (K&L Gates, Lawyers) for Opal Aged Care (formerly Domain Principal Group) Mr C Jackson instructed by Mr A Mineo (Avant Law) for Dr Asar Ms J Hopper instructed by Ms N Harvey (NSW Law Society Pro Bono Scheme) for Ms Z Stofan Mr R Gonzaga for Ms L Mateo Ms P Robertson (NSW Nurses and Midwives Association) for Ms J Mitchell Ms S Callan instructed by Ms A Malhotra (Dept of Planning & Environment) for the Department of Planning & Environment

Findings:	I find that **Alma Smith** died on 18 November 2011 at Quakers Hill Nursing Home, Quakers Hill, New South Wales due to smoke inhalation she suffered as a person with severe ischaemic heart disease and emphysema during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean. I find that **Dorothy Wu** died on 18 November 2011 at Quakers Hill Nursing Home, Quakers Hill, New South Wales due to smoke inhalation and burns she suffered during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean. I find that **Dorothy Sterling** died on 18 November 2011 at Quakers Hill Nursing Home, Quakers Hill, New South Wales due to smoke inhalation and burns she suffered during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean. I find that **Lola Joyce Bennett** died on 18 November 2011 at Royal North Shore Hospital, St Leonards New South Wales due to smoke inhalation and burns she suffered during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean. I find that **Ella Wood** died on 19 November 2011 at the Concord Hospital, New South Wales due to smoke inhalation and burns she suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean. I find that **Urbana Alipio** died on 20 November 2011 at the Liverpool Hospital, New South Wales due to the effects of smoke inhalation she suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean. I find that **Caesar Galea** died on 21 November 2011 at the Hawkesbury Private Hospital, Windsor New South Wales due to the combined effects of acute exacerbation of chronic airways limitation precipitated by smoke inhalation he suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean, and the effects of sigmoid colonic infarction.

Findings (cont'd):	
	I find that **Doris Mercy Becke** died on 21 November 2011 at the Blacktown Hospital, New South Wales due to the effects of smoke inhalation she suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean. I find that **Reginald Joseph Green** died on 25 November 2011 at Westmead Hospital, New South Wales due to the effects of smoke inhalation he suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean. I find that **Verna Noeleen Webeck** died on 29 November 2011 at the Royal North Shore Hospital due to the effects of burns and smoke inhalation she suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean. I find that **Neeltje Valkay** died on 22 November 2011 at the Liverpool Hospital, New South Wales due to the combined effects of smoke inhalation she suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean and a cervical spine fracture she incurred by falling out of bed in hospital following her admission after the fire. I find that **Esther Newham** died on 19 December 2011 at the Adventist Nursing Home, Kings Langley, New South Wales due to 'extreme old age' or natural causes although she had been exposed to some smoke on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean. I find that **Joan Joy** died on 4 December 2011 at Garden View Aged Care facility, Paton St, Merrylands, New South Wales due to a combination of age and natural causes including kidney disease, heart disease, chronic lung disease and gastrointestinal disease although the stress of being disconnected from her dialysis machine and of being removed from the nursing on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean may have been a contributory factor in her death.

Findings (cont'd)	
Findings (cont'd)	I find that **Emmanuela Cachia** died on 9 March 2012 at Westmead Hospital, New South Wales due to multiorgan failure probably due to sepsis resulting from a hospital-acquired infection following her admission for the effects of smoke inhalation she had suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean. I find that the fire at the Quakers Hill Nursing Home on 18 November 2011 was caused Roger Dean deliberately lighting fires in beds in ward 19 of the A2 wing and ward 3 of the A1 wing.

Recommendations:	I make the following recommendations to the **Minister for Emergency Services** and the **Commissioner for Fire and Rescue NSW:** • That the NSW government provide funding for the instalment of mobile data terminals in Fire and Rescue NSW vehicles; • That Fire and Rescue NSW develop a digital database of pre-incident plans for use in major structural fires; • That Fire and Rescue NSW develop and disseminate a 'lessons learned' e-learning package to all staff with particular emphasis on issues that arose in relation to the Quakers Hill Nursing Home fire. Topics of high significance would include urgent escalation of the alarm level for structure fires involving building occupied by large numbers of people; rescue techniques, especially the rescue of non-ambulant patients and patients attached to medical equipment; and management of hose lines jammed in fire doors. • That Fire and Rescue NSW and the Department of Planning work together to address the issue of hose lines becoming jammed in fire doors; • That, pending the results of any such consultation, Fire and Rescue NSW consider either issuing fire fighters with blocks or wedges to enable them to advance lines without undue hindrance or, alternatively, that, if resources and circumstances allow, whenever a hose line is being advanced, a fire fighter be tasked to keep advancing lines free until he or she is no longer required for that purpose; • That Fire and Rescue NSW consider issuing a bulletin to all aged care and other types of residential facilities in NSW identifying the difficulties encountered by fire fighters at the Quakers Hill Nursing Home fire and the lessons learned. In particular, emphasis might be laid on:

Recommendations (cont'd)	- The urgent necessity for at least one '000' (and preferably more than one) call to be made by staff following a fire alarm to give FRNSW time to 'scramble' appropriate resources to attend the fire; - That staff cross-check with one another to ensure that a '000' call has been made and to make one if unsure; - That staff members remove patients or residents then close ward doors and other fire doors as quickly as possible to confine fires within fire compartments; - That removal of non-ambulant patients and residents should, if reasonably practicable, be done by wheeling them out of danger in beds or wheel-chairs but that alternative dragging methods may need to be employed; - That if patients are wheeled out of their wards or rooms efficiently, passage ways must be kept as clear as is reasonably practicable; - That the facility's fire evacuation plan takes into account potential impediments to rescuing non-ambulant patients, such as connection to medical equipment, and makes specific provision for addressing those challenges in an emergency; - That fire exits and other doors be kept clear of obstructions that could hinder urgent movement of non-ambulant patients in the case of sudden emergency; - That facilities include in their fire and emergency training regular scenario-based practical training including practice of the urgent removal of non-ambulant patients and residents.

Recommendations (cont'd)	I make the following recommendation to the **Commonwealth** and **New South Wales Ministers for Health** and the **Chief Executive Officer of the Australian Health Practitioner Regulation Agency**: • That AHPRA consider requiring employers to notify it when a health professional falling under the agency's jurisdiction commences work and when he or she leaves that employment. I recommend that any regulatory changes necessary to implement such a practice be given urgent consideration; • That AHPRA consider including employment details in its registration data base. Those details might include name and contact details of the employer; period of employment; and any notifications made to AHPRA concerning the employee. I recommend that any regulatory changes necessary to implement such a practice be given urgent consideration I make the following recommendation to the **Commonwealth Minister Social Services** and the **NSW Minister for Ageing**: • That the Commonwealth Department of Social Services and the NSW Department of Aged Care, Disability and Home Care, in consultation with peak industry bodies such as Aged and Community Services Australia Inc, consider publishing in their media outlets directed towards services providing residential care a 'lessons learned' case study document dealing, in particular, with the issues of signs of drug-dependency among nursing staff and other health professionals; mandatory reporting requirements; scrutiny of employment records in which large gaps appear; security of Schedule 8 drugs; and emergency evacuation training. I make the following recommendation to the **NSW Ministers for Emergency Services** and **Planning** and the **Commissioner for NSW Fire and Rescue NSW**: • That Fire and Rescue NSW consult as to the best and most practical means for ensuring that in a structural fire, Fire and Rescue's hose lines can be advanced beyond fire doors without either jeopardising the integrity of fire compartments or jamming hose lines.

Recommendations (cont'd)	I make the following recommendations to the **NSW Minister for Health**: • That the Minister refer this case to the Poisons Advisory Committee to consider whether regulations under the Poisons and Therapeutic Goods Regulation 2008 should be amended to improve security of Schedule 8 drugs in nursing homes and similar facilities; • That the Minister consider requiring nursing homes by regulation to use identification armbands on all patients at all times unless there are overriding medical reasons not to do so.

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IN THE STATE CORONER'S COURT
GLEBE
SECTIONS 30 & 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This is an inquiry into the fire at Quakers' Hill Nursing Home, located at 35-37 Hambledon Road, Quakers Hill on 18 November 2011, and a combined inquest into 14 deaths of residents of the Nursing Home who died in the fire or in the period soon after the fire:

   - Urbana Alipio
   - Doris Mercy Becke
   - Lola Joyce Bennett
   - Emmanuela Cachia
   - Caesar Galea
   - Reginald Joseph Green
   - Joan Joy
   - Esther Newham
   - Alma Smith
   - Dorothy Sterling
   - Neeltje Valkay
   - Verna Noeleen Webeck
   - Ella Wood
   - Dorothy Wu

2. The fire was lit by Mr Roger Dean, a registered nurse employed at the home, at about 5 am. Mr Dean deliberately lit fires in two areas within the home. There were approximately 81 aged care residents residing at the home.

3. Mr Dean ultimately pleaded guilty to, and was convicted in respect of, eleven counts of murder by way of reckless indifference to human life. The murder convictions related to the deaths of Dorothy Sterling, Dorothy Wu, Alma Smith, Lola Bennett, Ella Wood,

Urbana Alipio, Caesar Galea, Doris Becke, Reginald William Green, Verna Webeck and Neeltje Valkay.

4. Mr Dean also pleaded guilty to, and was convicted of, recklessly causing grievous bodily harm to Marina Alegado, Emmanuela Cachia, Marisa Laconis, Lesley Trimmer, Romulo Feliciano, Thelma Hodgson-Budd, Anello D'Urso and Bithanta Muneshwar. He was sentenced to life imprisonment without parole. He has an outstanding appeal against his sentence.

5. Ms Joan Joy (died 4 December 2011), Ms Ester Newham (died 19 December 2011) and Ms Emmanuela Cachia (died 9 March 2012) were residents who were present at the time of the fire but were not the subject of the murder charges to which Mr Dean pleaded guilty.

6. Inquests into deaths and coronial fire inquiries are not trials. The primary aim of an inquest or a fire inquiry is to make findings of fact in relation to particular issues. Questions of criminal or civil liability are decided not by coroners but by judges in other courts.

7. As for the inquests, my role is to make findings as to the identity of the deceased persons, the dates of their deaths, the places of deaths and the manner and cause of deaths in accordance s 81(1) of the Coroners Act 2009. In this case, there are no real issues in these inquests in relation to identity of the deceased, or as to dates and places of deaths.

8. The real issues concern the manner and cause of death, and the circumstances in which the fatal fire was ignited. That in turn raises questions not only about Roger Dean's conduct but how he came to be in a position to light the fire in the early hours of the 18 November 2011, and how it was that the fire caused the deaths of residents of the nursing home.

9. In relation to the fire inquiry, my function is to investigate and identify the origin and cause of the fire, including causation of the spread of the fire. I must make findings as to the date and place of the fire and the circumstances of that fire in accordance with s 81(2) of the Act. Again, date and place are not in issue. The principal questions here concern the origin and causation of the fire, and the circumstances in which the fire was lit and spread.

10. There is obviously considerable overlap between the issues which arise in the inquest and in the fire inquiry.

11. A second, and very important, function of this inquest and inquiry is to consider whether to make recommendations under s 82 of the Act in relation to any matter connected with the deaths or with the fire with a view to seeking to prevent an event with such tragic consequences from ever occurring again.

The victims of the fire

12. Before focussing on the technical issues that arise in this case, it is important to emphasise that this is a story about human beings who lost their lives in terrifying circumstances due to a shocking crime.

13. Several of the families of those who died produced statements concerning the much-loved *living* people whom they lost and whom they now mourn. Other families, no doubt due to grief and a desire to avoid publicity in such circumstances, did not.

14. All the victims were elderly people who required high levels of care due to their advanced ages and ill-health. Almost to a person they had experienced real hardship in their younger days, having grown up in the Depression and Second World War, and having worked in the reconstruction period. Many had large families and relatively small incomes.

Reginald Green

15. Mr Green was born in 1924 and was married for 62 years. He and his wife Nola raised two children. Unfortunately, I have few details of his long life. At the time of his death he had been suffering dementia for some time. His family visited him regularly. He was survived by Mrs Green and their two children.

Joan Joy

16. Ms Joy was born in England in 1932. She emigrated to Australia in 1969. She suffered kidney failure and needed regular dialysis treatment. She was survived by her three children.

Esther Newham

17. Ms Newham was born in 1909 and had had her 102nd birthday two days before the fire. She suffered arthritis and found it difficult to walk. Her eyesight and hearing had failed and she was also inflicted with Dementia. She was survived by her son.

Ella Wood

18. Ms Wood was born in 1913 and married in 1939. She and her husband had one child. She was widowed in 2008. She was a frail but relatively healthy 97 year old woman who saw her family regularly.

19.

Dorothy Wu

20. Ms Wu was 85 years old at the time of her death. She had suffered Alzheimer's Disease since about 2005. Her husband died some years before. She was survived by her two sisters and two brothers.
21. Other families were able to provide more detail about their loved ones:

Urbana Alipio

22. Ms Alipio was born in 1925 in the Philippines and emigrated to Australia in 1994. She had three children and a number of grandchildren. If many elderly Australians lived hard lives, Filippinos who lived through the Second World War and the Japanese occupation of their country, had harsher crosses to bear. I have been told little about Ms Alipio but she must have been a resilient woman to have survived that experience and to have brought up her children in the aftermath of the war. I understand that the family is very close and grieves for her.

Doris Mercy Becke

23. Ms Becke was 96 when she died. She had brought up five children during the Depression and always worked hard. Life treated her hard in some respects. She was widowed at 48 and never remarried. She suffered breast cancer. But her family, which expanded over the years to include 13 grandchildren, 28 great-grandchildren and 24 great-great-grandchildren, was central in her life. Her family described her as a 'fighter until her last day' with a 'happy and positive' spirit.

Lola Joyce Bennett

24. Ms Bennett was born in 1925 and was married for 31 years, raising two children. She was widowed in 1975. She grew up on a farm and during the Second World War was a member of the Land Army. Her marriage was a hardworking but happy one, with two children being born to her. The whole family participated in working the banana plantation they owned. Life for her was not all work – she loved dancing and played the organ. She was a woman whom her family remembers as strong, industrious but also generous-hearted and fun. She too is much missed.

Emmanuela Cachia

25. Ms Cachia was described by her family as 'a loving wife, a caring mother and a gentle grandmother who meant the world to everyone around her.' She was born in Malta in 1935. She emigrated to Australia in 1956 with her parents and her three siblings. She married and raised five children but was later widowed. She loved family gatherings and trips to the Blue Mountains and La Perouse, especially with her extended family. Her death has been an enormous blow to the whole family.

Caesar Galea

26. Mr Galea's family described him as a 'strong and proud man', devoted to his family and who adored his grand-children. He had been married for about 62 years before he entered the nursing home, a blow to the whole family. He was born in Alexandria, Egypt in a Catholic family of Maltese descent. He became a skilled leatherworker in Egypt before emigrating to Australia after the Second World War. For 20 years, he worked as a Special Constable with the NSW Police Force. He was a keen cook and enjoyed fishing, growing vegetables, greyhound and trotting races but most of all his large extended family who loved him greatly and miss him very much.

Alma Smith

27. Ms Smith was 73 at the time of the fire. She was born in the country but lost her mother at the age of 2 years. Her childhood was difficult as her father was away from home for work a great deal and she was sent to boarding school at 11 years. Like many young people of her generation, life was no easy journey. Her first marriage ended tragically in a car crash and in later life she became too ill to live at home. Her family described her as a woman who sacrificed herself for others and who refused to be a burden on the family, but also a person who tried to remain positive for them as she aged and became more frail.

Dorothy Sterling

28. Ms Sterling was born in 1931 and was a talented seamstress, making dresses and wedding gowns during her working life. She had two sons, five grand-children, 13 great-grandchildren and one great-great-grandchild. Although she was not German, she was nicknamed 'Oma' ['grannie'] by the family. She was a warm, affectionate and generous matriarch within the family and is much missed.

Neeltje Valkay

29. Ms Valkay was born in Holland and married in 1946. She had three children. The family emigrated to Australia in 1954 for opportunity for the children and better weather. In 1987 she was widowed. She was a talented soprano who sang in choirs in both Holland and Australia and even in her old age her love of music and singing remained undiminished. She was an intelligent woman who became known at Quaker's Hill Nursing Home as "the Trivia Queen". Her family was at the heart of her life, and she is much missed by them.

Verna Webeck

30. Ms Webeck, like so many of the victims of this fire, was born into tough times and circumstances. She was born in 1928, one of 11 children. Her father had been a soldier and the family's military connection remains strong, her grandson Michael recently

serving in Afghanistan with the Australian Army. She was a resilient woman, used to working hard in hard times, perhaps first developing such strength as a shearer's cook and later working in a nursing home. Her strength enabled her to survive a bout of cancer when one of her children son was only 18 months old. She was mother to five children and grandmother and great-grandmother to a large extended family, all of whom admired and loved her.

The nature of an inquest and the coroner's role

31. These proceedings concern fifteen separate cases: an inquest into each of the deaths and an inquiry under s 30 of the Coroners Act 2009 into the cause and origin of the fire.

32. An inquest is an inquiry or an investigation, not a criminal or civil trial. Although Roger Dean's conduct has been closely considered during this inquest, the purpose for doing so was not to establish his guilt – he has admitted that and been sentenced for it – but to consider how the fire came about and whether there are lessons that can be learnt from this terrible tragedy that may reduce the risk of harm to others in future.

33. The formal purpose of an inquest is to make findings of fact about five things. A coroner must, if possible, make findings concerning the identity of those who died and the date and place of their deaths. A coroner must also identify the cause of death, that is, the physiological mechanism of death. Finally, a coroner must seek to determine the manner of death. In that respect, the questions are "How did this death come about?" or "What were the circumstances of the death?." We are also investigating the cause and point of origin of the fire. There is obvious overlap of those issues and the question of manner of death.

34. Much of what follows concerns technical issues. At its heart, however, this is a case about much-loved and respected human beings whose lives were ended suddenly and prematurely in terrifying and tragic circumstances.

Factual Background

The Quakers Hill Nursing Home

35. As at 17 November 2011 the Quakers Hill Nursing Home was owned by a company which is now known as Principal Finance Health Care No. 3 Pty Ltd which is part of the group of companies previously called the Domain Principal Group. That group is now known Opal Aged Care.

36. As at 18 November 2011, Principal Finance Health Care held accreditation from the Australian Aged Care Quality Agency to operate a residential aged care facility. Accreditation is not necessary to operate an aged care home but some funding from the Commonwealth is dependent upon accreditation.

37. The nursing home catered for high care residents who require assistance with daily

living. Many of the residents suffered from dementia and some were bed-ridden, factors that significantly affected the scale of this disaster and complicated the rescue and fire-fighting operations. This issue is of some of significance when considering what steps need to be taken to ensure that any evacuation of residents in the event of a fire can safely be carried out with the maximum chance of safely evacuating all residents.

The structure of the home and fire safety requirements

38. The nursing home was divided into the four wings. Wing A1 consisted of eight rooms, numbered 1 to 8, each capable of accommodating four residents. Wing A2 consists of eight rooms with single beds and four rooms with two beds, numbered 9 to 22.

39. The building itself was constructed in about 1981 or 1982 pursuant to a development consent for a 100-bed nursing home and a building permit issued by the Blacktown City Council on around September 1981.

40. The building was on a single level with double brick construction and plaster port linings glued to the internal brick walls and the ceilings were also plasterboard. Each wing constituted a separate fire compartment. To maintain this separation, fire doors were positioned at the internal entrance to each wing.

41. The fire doors were designed to automatically close upon activation of the fire alarm to contain a particular fire within the wing in which it had started. Smoke sensors were positioned throughout the building. The fire compartments appear to have been compliant with the applicable Australian Standards.

42. A fire indicator panel and an emergency warning intercom system panel were positioned next to each other in the front lobby. The A1 wing was accessible internally from the front foyer or via the exit at the western end where there was the L-shaped ramp with a steel railing.

43. There were also 16 CCTV motion activated cameras installed internally and externally around the nursing home.

44. It was a term of both the development approval and the building permit that water hydrants were to be installed in suitable positions so that no part of the building was more than 90 metres from a hydrant internal or external and that hose reels were installed in suitable positions throughout the building. There was a hydrant at the front of the nursing home. This was not identified by firefighters when they arrived at the incident, they used a hydrant on the street rather than the hydrant specifically designated for the nursing home.

45. The fire safety requirements applicable at that time also included a range of additional measures. First, it was a term of the building permit that there would be compliance with what was known as the 'Hosplan Code' and with a letter from the New South Wales Board of Fire Commissioners. That letter included a number of requirements in relation to doors, lining material used in the construction of walls and ceilings, installation of

smoke detectors, closing fire and smoke doors and alarm systems.

46. The Hosplan planning and design note, which was published by the New South Wales Hospitals Planning Advisory Centre, made recommendations in relation to requirements for private hospitals such as this ranging from fire compartments, smoke compartments to egress. Fires in nursing homes obviously pose significant risks to patients and residents. The Hosplan therefore required that roof spaces would not exceed a certain area (300 square metres) and they be divided into compartments by materials fire-rated to one hour. After the fire, investigators from Fire and Rescue New South Wales inspected the site and identified no evidence of failure to comply with this requirement.

47. Ordinance 70, issued under *Local Government Act 1919*, also applied to the home. It specified mandatory fire safety requirements for particular classes of buildings. After the fire an inspection identified some non-compliance with current Australian Standards in relation to hydrants but there appear to have been no material effects on this fire.

48. There were also requirements relating to width of doorways and prohibitions on timber purlins and other combustible material passing through or crossing fire walls. Although the post-fire investigation found a breach of the latter, it did not affect the spread of the fire.

49. Private hospital regulations also specified a number of fire safety requirements including egress and structural requirements. Clause 6A of these regulations provided that the efficiency of each means of escape must be maintained.

50. Relevant fire safety standards are almost entirely established at the time of the development consent or building permit is granted.

51. An exception to this general practice relates to sprinklers. After the Quakers Hill fire legislation was introduced with retrospective effect requiring that aged care homes in certain categories install sprinkler systems.

52. A second exception is that all nursing homes are required by regulations under the Environmental Protection and Assessment Act to file an annual fire safety statement certifying essential fire safety measures are operating to a standard no less than that to which it was originally designed and implemented.

53. Under regulation 176 the person carrying out the assessment must inspect and verify the performance of each fire safety measure being assessed and there is also a statutory obligation on the owner of the building under regulation 182 for each essential fire safety measure to be maintained. So the standard of compliance is that which would have been applicable at the time when the original development consent or approval was granted unless there has been a more recent development consent or approval that triggered a requirement for a further safety Schedule.

54. Under regulations 184 and 185 of the EPA regulations, it is an offence to install something that may impede the free passage of persons in a ramp forming a building's

fire exit or to obstruct a doorway that forms part of a building fire exit.

Nursing staff arrangements

55. At the time of the fire, Ms Zuzana Stofan was the facility manager and Ms Luneta Mateo, who was the registered nurse, worked as the clinical manager. Ms Mateo had been working as the clinical manager responsible for the supervision of staff since 25 July 2011 when, according to Ms Stofan, she had been temporarily appointed to that position having previously worked as a registered nurse at the nursing home. Ms Mateo's role made her second-in-charge to Ms Stofan for the running of the nursing home but, apart from managing the nursing staff on a day-to-day basis, she appears to have had few management responsibilities.

56. The nursing staff worked in three shifts in each day with the night shift running from 10.30pm to 7am. More than one registered nurse was rostered at a time during the morning and day shifts but not on the night shift. The night shift was typically staffed by one registered nurse, who was in charge of that shift, and four assistants-in-nursing (sometimes referred to as AINs).

57. Medications, including drugs of addiction or Schedule 8 drugs, were stored in the treatment room at the nursing home. The treatment room is near the entrance to the B2 wing. A CCTV camera monitored the area around the treatment room.

58. A blue lanyard key opened the treatment room door and a red lanyard key then opened the drug of addiction cabinet. The Schedule 8 register, in which usage of Schedule 8 medication used was recorded, was generally stored within the drug of addiction cabinet within the treatment room. To gain access to it both the blue lanyard key and the red lanyard key were needed. The keys were generally kept with the registered nurse on duty. Schedule 8 drugs could only be dispensed by registered nurses. To prevent theft or illicit use of Schedule 8 drugs, dispensing of Schedule 8 drugs had to be witnessed by another person, generally a nurse, and each instance recorded in the register.

Roger Dean's background

59. Mr Dean was born in 1976 and registered as a nurse on 23 December 1996. He worked with St George Hospital and Community Health Services, in the areas of mental health and drug and alcohol rehabilitation, between 2002 and 2007. In April 2007, he had a dispute with his supervisor, Ms Tracey Sheehan, concerning notes that he had made on a patient file. Mr Dean became upset and complained to her that she was being condescending and unfair. On 9 May 2007, Ms Sheehan found her car damaged in the work car park with paint splashed over it and screws in the tyres. She suspected Mr Dean was responsible. Her manager, Joanna Townley observed white marks on his desk that appeared similar to the paint found on Tracey Sheehan's car. An investigation was to be carried out. Mr Dean resigned in July 2007 very soon after the investigation was announced. During the preparation for his sentencing after the fire, he admitted to Dr Michael Diamond, who was preparing a psychiatric report for the court, that he had thrown paint on Ms Sheehan's car.

60. Mr Dean commenced studying for a Bachelor of Laws degree in 2004 at the Macquarie University and was one unit short of completing that course at the time of the fire.

61. In September 2005, while still working at St George Hospital, he commenced casual work with St John of God Hospital. In July 2007, after he resigned from the St George Hospital and Community Health Services, he was appointed to a permanent registered nurse position at the St John of God Hospital, working primarily night shifts.

62. On 18 June 2011, Mr Dean was found drug-affected at work at St John of God Hospital. According to St John of God Hospital records, a patient (who was also a police officer) found Mr Dean in the medication room. After the fire, this patient reported to police that Mr Dean had appeared significantly drug-affected and that he had been unable to administer her medication properly, or even to remember what her medication despite it being written down in front of him. His clothing had appeared dishevelled. He had had spittle or white froth in the corners of his mouth, was talking slowly, had slurred speech and appeared uncoordinated. She notified other staff. The After Hours Manager, Ms Karen Bailey, then spoke to Mr Dean in response to the notification. She described him as appearing at the time to be ataxic and sedated, and said that he had been slurring his speech. She suspended him from duty immediately and sent him home. Ms Bailey insisted that he not drive himself home.

63. On 21 June 2011, Mr Dean was interviewed by Mr Paul Dyer, the Director of Nursing for the hospital, and Kathy Bond, the Nurse Unit Manager. Mr Dean advised them that :

- he had bipolar disorder;
- his GP had changed his anti-depressant medication;
- it had adversely affected him on the day in question; and that
- he had since seen his GP and had his medication regime changed.

64. He also told Ms Bailey that he had been seeing a clinical psychologist fortnightly for a major depressive illness.

65. Mr Dyer requested a letter from Mr Dean's GP to confirm he was fit to return to work. He was to remain on suspension until that occurred. Dr Sadiq Asar of Nirimba Medical Centre saw Mr Dean on 20 June 2011. Dr Asar noted that Mr Dean was "well and stable" and had started back on Seroquel. It appears there was a change to Mr Dean's medication at this time. Mr Dean then presented Mr Dyer with a signed letter in the name of Dr Asar dated 20 June 2011 that confirmed he suffered bipolar disorder with a strong depressive tendency and that he had been prescribed Loval[1], Seroquel and

[1] A drug that reduces nausea and vomiting.

Imovane[2]. The letter asserted that Mr Dean was stable and fit to resume his duties as an RN. There was probably another incident in May 2011 but records are unavailable.

66. Mr Dean's suspension ended following the presentation of that letter. It also appears that St John of God management thereafter considered Mr Dean to suffer bipolar disorder.

67. In his statement, Dr Asar said that he had treated Mr Dean for anxiety and panic disorders for which antidepressant and sleeping medications were prescribed. He made no mention in his statement or his consultation notes of Mr Dean suffering from bipolar disorder. There is no evidence that Mr Dean ever underwent a specialist mental health assessment or treatment, much less that he was ever formally diagnosed with bipolar disorder.

68. It is possible that Dr Asar floated the possibility of bipolar disorder with Mr Dean as possible explanation for his symptoms, although no formal diagnosis was made. Dr Diamond noted Mr Dean's self-report that his "*…erratic state was thought to be evidence of bipolar disorder by Dr Asar, who then added the major tranquilliser Seroquel 300 mg at night*".

69. Mr Dean resigned from St John of God Hospital in September 2011. Prior to his resignation he had filed a complaint against another staff member which was in fact found to be substantiated. However, it appears that management at the St John of God hospital considered that Mr Dean had a compromised ability to communicate and manage relationships with others. With patient safety in mind, Mr Dyer advised Mr Dean that he was to be taken off night shift and moved to day duty to ensure that he received appropriate supervision.

70. Three days after that decision was communicated Mr Dean resigned. His notice of resignation dated 19 September 2011 listed "*personal reasons*" as the basis for his departure.

71. None of the information relating to his circumstances or termination of employment was ever communicated to anyone at the Quakers Hill Nursing Home nor did anyone at Quakers Hill Nursing Home ever make inquiries with the St John of God Hospital concerning his reasons for resigning or his performance as a nurse there.

Roger Dean's employment with the Quakers Hill Nursing Home

72. In September 2011 Mr Dean was sharing a unit with his then partner, Mr Dean French. Mr French owned and ran the Cheesecake Shop in Quakers Hill. The unit was within walking distance of the Quakers Hill Nursing Home.

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[2] A sleeping pill.

73. Mr Dean visited the home some time in early September 2011 to enquire whether they had work available. The home needed a registered nurse, especially one who could cover night shifts. Mr Dean provided the Quakers Hill Nursing Home with a copy of his resumé, registration form and other documents on or before 6 September 2011.

74. As well as his resumé, he also provided a number of written references from former employers that dated back to 1998 and 2000. There are a number of curiosities about the curriculum vitae that Mr Dean presented to the Quakers Hill Nursing Home. The most important is that the only employment listed from 9 August 2007 to 'current' was work at the Cheesecake Shop in Kellyville. The most recent nursing experience listed was at the St George Public Hospital, ending on 6 July 2007.

75. The only aged care experience identified was for approximately two years in 2002-2004.

76. The referees listed were Mr French of the Cheesecake Shop and Mr Benardi of St Vincent's Hospital where, according to Mr Dean's resumé, he had only worked between 22 May and 11 August 1997. Further referees were identified as Ms Natalie Cutler and Mr Kevin McLoughlin and Mrs Amanda Barnes from St George Hospital/SE Sydney Illawarra Health Service. None of these people had worked with Mr Dean since 2007. Three letters of reference from Ms Barnes were dated 1998, 1999 & 2000, and two from a Ms Bouvy of the Nightingale Nursing Bureau Limited were dated 1998 and 1999. Thus, the most recent written reference related to the year 2000, 11 years prior to his proposed employment at the nursing home. Mr Dean's resumé specifically mentioned that he would like to move to permanent work on night shifts. Most notably, his curriculum vitae omitted any mention of his St John of God employment.

77. No member of the Quakers Hill Nursing Home staff got in touch with his referees or his previous employers. He was employed on the basis of the misleading CV, references that were seriously out of date, although he had current registration as a nurse, and one interview. He was appointed soon after the interview as a permanent part-time nurse. As was his preference, he was mainly rostered to work night shifts.

78. Mr Dean's contract of employment, signed by Zuzana Stofan, was dated 20 September 2011. He was thereby engaged as a permanent part-time registered nurse level 1, with night shifts on Wednesday and Thursday nights and a Saturday morning shift. Attached to the contract of employment was a Code of Conduct. The code required that he should carry out his work in an ethical fashion and perform his work with integrity and honesty. Although it hardly needed to be spelled out, the code emphasised that behaviour endangering the safety and well-being of others was "inappropriate".

79. Although it is not clear whether or not compliance with the Code of Conduct was a condition of the contracts of employment of all Principal Healthcare employees at the Nursing Home, it is pertinent to note that one of the requirements of the code was those bound by it "consider the desirability of intervening constructively where a colleague's

behaviour is clearly in breach of this code" and "consider the impact of decisions [made by staff] on the well-being of others".

80. The prerequisites for the position included a current police check, experience supervising staff and qualification and current registration. Desirable or highly desirable competency requirements included experience working in an aged care environment.

81. The Principal Healthcare organisation's employee engagement checklist included obtaining a police check, but did not include checking references. This checklist was completed on 7 September 2011. Principal Healthcare's protocols also included a requirement that nurses being considered for employment undergo a medical screen. In Mr Dean's case, however, no pre-employment medical screening took place.

82. Mr Dean attended in-service staff training at the Quakers Hill Nursing Home on 6 September 2011. That training included sessions on fire safety. Employment records show that Mr Dean commenced working night shift at Quakers Hill Nursing Home on 13 September 2011.

83. At the nursing home only one registered nurse worked on night shift. Thus, on night shift, Roger Dean was effectively unsupervised during the course of a shift. Moreover, overnight he would have been the only person with a key to the treatment room, where Schedule 8 medication is stored, and with access to the keys to the Schedule 8 medication cupboard. This ensured that if he was in that room with the door locked, he could be confident that no-one else could come in.

84. Mr Dean was employed with a three-month probationary period with Ms Stofan as his supervisor. She was to conduct a performance appraisal at the conclusion of his probationary period. After the fire a number of Assistants-in-Nursing mentioned incidents involving Mr Dean that, before the fire, had caused them some concern. At the very least, there is evidence that some complaints were verbally reported to Ms Stofan just prior to the fire and noted by her. The fire, of course, interrupted the probationary period.

Roger Dean's shift on 16 to 17 November 2011

85. Mr Dean worked a night shift along with AINs Ms Judith Watt, Ms Sidonia Thompson, Ms Maria Gratil and Ms Lence Darley on 16 to 17 November 2011.

86. During that shift all the AINs noticed Mr Dean spending time in the Treatment Room on his own, often with the door closed. This stood out as it was unusual for a registered nurse to spend time in that room on his or her own, especially with the door shut.

87. Towards the end of the shift Ms Darley entered the treatment room whilst Mr Dean was there. She observed blister packs on the trolley in the room and that clear sticky tape

had been wrapped around one of the packs. Mr Dean told her that nurses had ripped the packets and that he had to tape them up.

88. A camera was positioned outside the Treatment Room door and captured people entering and exiting that room. A subsequent review of CCTV showed that Mr Dean entered the treatment room on 36 occasions and spent, in total, over 2 hours of his shift in there that night.

89. Before going off shift, perhaps to pre-empt any complaint or report that might be made against him, in an apparent attempt to ingratiate himself with Ms Stofan, Mr Dean typed a letter to her, offering to run fortnightly clinical supervision for staff. This was placed under her door.

Discovery of the missing medication on 17 November 2011

90. Nursing homes are required by law to keep a register of drugs of addiction and to store and allow access to them only under controlled conditions. Entries must be made in the register on the day on which a person receives, supplies or administers a drug of addiction. That entry must be dated and signed by the person who made it and countersigned by a witness.

91. The nursing home had two blue drug register books. They were stored in the Schedule 8 cabinet.

92. The nursing home required registered nurses on afternoon shift physically to account for all Schedule 8 drugs against the drug register each day. This audit was usually performed by a registered nurse or enrolled nurse before 8 pm each evening.

93. Ms Janette Mitchell RN and Ms Deepa Kunwar AIN commenced the audit about 7:35 pm on 17 November 2011. Ms Mitchell discovered that the counts for Endone[3] did not tally with the numbers listed against the patient's name and that Endone tablets were missing from blister packs and boxes.

94. Ms Mitchell contacted the nurse who had completed the audit the day before and confirmed that nothing out of the ordinary was detected in that audit. Ms Mitchell then contacted Ms Berlin RN, who had worked the morning shift, and was told that no Endone had been administered during the morning shift.

95. Ms Mitchell called Ms Stofan and left a message about the missing medication. She then contacted Ms Luneta Mateo about 8 pm. According to Ms Mateo, she was told that "*a lot of Endone 5 mg tablet medications were missing*" and about the inquiries Ms Mitchell had made with the previous shifts. Ms Mitchell advised her that Mr Dean had been the night RN the night before.

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[3] A narcotic analgaesic.

96. In the nine years she had worked at the nursing home, Ms Mateo had never before had medication go missing.

97. Ms Mateo attended at about 8:30 pm and did a recount with Ms Mitchell. In total 237 tablets of Endone and one tablet of Kapanol, both opioid medications, were found to be missing.

98. According to Ms Mateo, both she and Ms Mitchell were "*a bit panicked about what to do as we'd never encountered this*". Ms Mitchell confirmed that she had not given the treatment room and Schedule 8 keys to anyone during her shift that afternoon. Ms Mitchell advised Ms Mateo that the last person recorded to have administered Endone to a resident was Mr Dean.

99. Ms Mateo then called Ms Stofan and advised her about the quantity of medication that was missing. Ms Stofan advised that she had left a message for her superior Robert Johnson but had not yet heard back from him. According to Ms Mateo, both she and Ms Stofan suspected that Mr Dean was responsible for the missing medication. They decided that Ms Mateo would ring the police and that Ms Mateo would remain at the facility until police arrived.

100. Sometime that evening Ms Stofan called the General Manager, Mr Robert Johnson, and notified him about the missing medication and that the police had been called. According to Mr Johnson, he was not told that there was a suspect and he was comfortable that the appropriate response was to call police to investigate. He was not contacted again prior to the fire.

101. Ms Mateo called the Quakers Hill Police Station at about 10:10 pm and reported that the medication had been stolen but did not, to quote Ms Mateo, "*tell* [police] *we had a suspect*". Before they left, Ms Mateo checked the bags of persons who worked the afternoon shift.

102. The night shift staff, Mr Dean RN and Ms Watt, Ms Thompson, Ms Gratil and Ms Alveena Chand, started to arrive at about 10:15 pm.

103. Ms Mateo had conversations with a number of night shift staff who had been working the previous night prior to Mr Dean's arrival. She discussed the night before and the missing medications. According to Ms Mateo:

- Ms Thompson AIN stated that Mr Dean had gone into the treatment room and locked himself inside and stayed there most of the night. Mr Dean had also woken a resident, Ms Thelma Hodgson-Budd, to administer her Endone after 4 am. It was unusual to wake a patient to administer medication and it was not clear that she had requested her pain relief;

- Ms Watt said that Mr Dean had locked himself in the treatment room for a long time;

- Ms Gratil told Ms Mateo that during the evening she had at one point been just outside the treatment room and heard what she described were blister packets popping coming from inside the treatment room. Ms Gratil also told her that she was "scared of Roger" and about a white lining that he would get in the corner of his mouth. (This observation of a "white lining" on Mr Dean's mouth was significant because it was consistent with the observations made when Mr Dean was found to be drug affected at the St John of God Hospital earlier in 2011.)

104. Ms Mateo told some of the staff not to tell Mr Dean anything when he arrived.

Events on 17 to 18 November 2011 prior to the fire

105. Mr Dean arrived just before 10:30 pm.

106. Ms Kunwar was an agency nurse who was working for that night. She had been asked to stay on after the day shift ended to await the arrival of police. It appears she was unaware of Ms Mateo's instruction not to inform Mr Dean about the missing medication. Ms Kunwar spoke to Mr Dean and told him what had happened and showed him her written report about the missing drugs.

107. Ms Mitchell RN performed a handover with Mr Dean. She says she handed over the red lanyard key but not the one to the Schedule 8 cabinet.

108. At about 12:04 am Constable Ben Mulder and Constable Vladimir Zacherl arrived at the nursing home. Both were let in by Mr Dean.

109. Ms Mateo spoke to the officers. The officers asked to look at the Schedule 8 cabinet to check for forced entry but it was evident that the door had not been forced. Ms Mateo spoke to the police in general terms about staff who might have had the opportunity to get into the room and the procedure with the keys. According to Ms Mateo, "*I didn't mention any specific names about who I suspected of having taken the medication. I didn't tell them about Roger*". Ms Mateo explained to police that the entry to the treatment room would have been captured on CCTV footage.

110. About 17 minutes after their arrival, Constables Mulder and Zacherl were called away to attend an urgent job. According to Ms Mateo, she was advised that they would call her if they were unable to return. She was frustrated at this state of affairs but "*held onto the promise that they would come back*".

111. Ms Mateo informed Ms Stofan by phone that the police had arrived but had then been called away to an urgent case. Ms Mateo stated that she would stay on until the police returned.

112. After the police left, Ms Mateo and Ms Mitchell re-entered the treatment room and placed six blister packs, from which drugs were missing, into plastic sleeves for the purposes of future fingerprinting. Those sleeves were taken into Ms Stofan's office.

113. In the office, Ms Mateo and Ms Mitchell viewed CCTV from the previous night shift and saw that Mr Dean had entered the treatment room numerous times by himself. Mr Dean was seen on the footage to come out with one of his arms stiff and rigid to one side of his body as though he had something tucked under it.

114. According to Ms Watt, Mr Dean appeared "*…very restless…anxious…"* during that shift. She said that he had asked her outside on one occasion spoke to her about the missing medication. He said, "*They think it's me"*. Mr Dean also approached her more than once and asked when are "*they* (Ms Mitchell and Ms Mateo) *going home*".

115. Ms Mitchell eventually went home at about 2:15 am.

116. At about 2:30 am, Ms Mateo called Quakers Hill Police Station to find out what was happening. Ms Mateo spoke to Constable Kristen Grech. According to Ms Mateo, she told Constable Grech about the missing medication and that she had viewed the CCTV. She described what she had seen on the footage and stated that the man seen in the footage was working that night with her staff. She also told Constable Grech that she was "*scared to leave my staff alone with him*". Constable Grech told her that police were attending to more urgent jobs and were unable to attend at that time.

117. Ms Mateo then spoke with Constable Mulder who had arrived back at the police station. According to Ms Mateo, he explained he had been called away with more urgent jobs and apologised for not calling her. He told her that, given the time, it was best if she went home and that police would speak with her in the morning.

118. Ms Mateo then called Ms Stofan and "*…updated her on what was happening"*. According to Ms Mateo, Ms Stofan told her to go home and that they would deal with it tomorrow. She also said that she had raised the question of sending Mr Dean home because the nursing staff were scared of Mr Dean and the police were not going to arrest him that night. Ms Mateo's evidence was that Ms Stofan had dismissed this idea saying, *"They're old enough to look after themselves."*

119. According to Ms Stofan, Ms Mateo told her that police said they would come back in the morning when there was a Facility Manager on site. Ms Mateo had also stated "…*I am feeling really tired and the staff are scared*". When asked what she was scared of, Ms Mateo had said, "*I don't know, they are just scared"*.

120. During the investigation, Ms Stofan stated to police that she thought the staff might have been feeling scared because the police had attended. (This seems unlikely – the police had in fact been called because of staff concerns about Roger Dean's conduct.) Ms Stofan denied being told by Ms Mateo that the staff was scared of Mr Dean. At the end of the conversation, she told Ms Mateo to go home and rest as she had to be back for the morning shift. Ms Stofan stated that before the call ended she asked Ms Mateo "*How is Roger?*" and was told, "*Yes, he is here and he is just normal*". According to Ms Stofan, Ms Mateo did not tell her that on the CCTV footage she had seen Mr Dean exiting and entering the treatment room numerous times during the previous night shift. This too seems unlikely given Ms Mateo's anxiety.

121. Ms Mateo decided to go home because she was very tired and because the police were not going to attend until the morning. Ms Mateo informed the AINs on shift of this fact. According to Ms Mateo, Ms Gratil and Ms Thompson "*begged me to stay; they said they were scared to be left alone with Roger*".

122. According to Ms Thompson, she called out to Ms Stofan, whilst Ms Mateo was speaking to her by phone, and said "*Zuzana, if you can hear me please don't send Luneta home or send somebody because I am scared for all of us*".

123. Ms Mateo left the facility at about 3:43 am. She left the plastic sleeve containing the blister packs and the CCTV footage in Ms Stofan's office, which she locked prior to leaving. Only she and Ms Stofan had keys to that office.

124. When Ms Mateo left the nursing home that night, despite her obvious misgivings, she left Mr Dean in possession of the blue lanyard and key for the Schedule 8 cabinet. In her evidence she explained that she had felt 'helpless' because she felt that she had no other choice. [Schedule 8 drugs cannot be dispensed by Assistants in Nursing. Only Registered Nurses and doctors have that authority.]

125. The police log for the 17/18 November 2011 indicates that at around 4.50 am police called the nursing home and spoke to Ms Watts who indicated that the person of interest for the theft of the medication was in fact working that shift. The police decided there was no point attending at that time if the manager was not on duty.

Lighting the fire in the A2 wing

126. At about 4 am Ms Judith Watt had a cigarette break outside. Consistent with her usual practice, she then left her cigarettes and lighter in between the ice machine and wall in the dining room. At some point after her break, Mr Dean entered the dining room and took her lighter.

127. At about 4:35 am Mr Dean approached Ms Watt and Ms Chand at the B wing nurses' station and said to them, "*I want you off the floor and I'll look after this side, get off the floor*". Ms Watt refused as they had already had their break.

128. Mr Dean then approached Ms Sidonia Thompson and Ms Maria Gratil and said to the effect, "*Why don't you guys take a break, you deserve it*". Ms Thompson and Ms Maria Gratil then went to the TV room to have a break.

129. At about 4:51 am Mr Dean made his way from the A wing nurses' station, which was unoccupied at the time, into the A2 wing.

130. In a record of interview with police, Mr Dean admitted that he made his way to ward 19, an unoccupied room, and used Ms Watt's lighter to set fire to a sheet on a bed. Mr Dean then left the room, leaving the door open, and returned to the front foyer.

131. Mr Dean was captured on CCTV at about 4:53 am back in the front foyer near the A wing nurses' station. He was walking towards the entry to the A1 wing. As he did so the fire indicator panel began to flash and all fire doors automatically closed. The fire alarm sounded at this time as well.

The Fire Indicator Panel and automatic fire alarm

132. The Fire Indicator Panel had a single line LCD screen. Zones were listed below in vertical order with corresponding alarm lights. When a sensor activated in a specific zone a corresponding light flashed on the panel. The first alarm to activate would show on the LCD screen and be designated as number 1. Subsequent zone activations would be numbered sequentially and show up as additional alarms. The Fire Indicator Panel operator could view the alarm sequence on the LCD by scrolling through the controls on the panel. It is not clear whether or not staff at the nursing home were aware that they could get additional information about one or more fire locations by scrolling through entries on the LCD panel.

133. When the primary Fire Safety Officer, who was Ms Stofan, was not present, it fell to the Registered Nurse on duty – in this case, Mr Dean - to go to the Fire Indicator Panel and check the location of the fire alarm, then relay this information to all staff and call triple zero. He or she was also required to co-ordinate staff to deal with the emergency.

134. The activation of the fire alarm caused Chubb Security to be notified electronically. An automated alert was then sent to Schofields Fire Station and Blacktown Fire Stations. Schofields Pump 96 (P96) and Blacktown Pump 63 (P63) were immediately dispatched. At this stage they were responding to an automatic fire alarm. Automatic fire alarms are, of course, treated seriously and with an emergency response. But because they are frequently false alarms, they do not lead to a large number of fire appliances being called out in the first instance.

Lighting the fire in the A1 wing

135. Some time between about 4:53 am, when he entered A1 wing and 5:02 am (when the smoke was first seen outside the A1 wing's fire doors by Station Officer Brett Johnson), Mr Dean ignited a second fire in ward 3 of the A1 wing.

136. In his subsequent interview with police, Mr Dean stated that he had entered the A1 wing and found a resident "Molly" out of bed looking for the toilet. He assisted her. He then used Ms Watt's lighter to set fire a sheet on the bed located in north east corner of ward 3 next to the doorway. It appears that it may have been Ms Mary Douglass' bed.

137. Ms Dorothy Sterling and Ms Dorothy Wu, aged 80 and 85 years respectively, were in their beds positioned up against the eastern wall in ward 3. Both suffered Alzheimer disease and other health problems. Both were bed-ridden. A fourth bed, occupied by Ms Bertha Leonard, was positioned in the north-west corner of the room.

138. After lighting the fire in ward 3, Mr Dean made his escape, leaving the room's door open.

Initial response by the nursing staff

139. Ms Watt was in the B wing speaking on the phone to police when she heard the alarm. She and Ms Chand quickly made their way to the Fire Indicator Panel. They were captured on CCTV at about 4:54 am inspecting the panel. Ms Thompson and then Ms Gratil arrived in the front foyer shortly afterwards. According to Ms Watt, the Fire Indicator Panel indicated at that point that a sensor had been activated somewhere between room 9 and 22, which was in the A2 wing. The sensor was obviously picking up signals from the fire in ward 19.

140. Ms Watt then answered the phone at the A wing nurses' station, which was probably a call from Chubb Security confirming the alarm activation.

141. At about 4:55 am, Ms Watt, Ms Thompson, Ms Chand and Ms Gratil entered the A2 wing through the fire doors. The CCTV footage shows that Ms Thompson returned shortly afterward and stood by the front entrance apparently waiting for emergency personnel to arrive.

142. Entering A2 wing, Ms Watt and Ms Chand saw smoke coming from ward 19. Ms Watt saw large flames as high as the walls and climbing the ceiling in room 19. She closed the door to contain the fire. That simple act, which limited the fire's access to oxygen and contained the smoke within that room, in all likelihood stopped fire and significant smoke spreading within the A2 wing.

143. Ms Watt and Ms Chand then joined Ms Gratil in evacuating residents out of the A2 wing and Ms Thompson remained at the front entrance awaiting the arrival of fire fighters.

144. Presumably because they believed that the source of the fire had already been identified, it seems that none of the nursing home made any further checks of the Fire Indicator Panel. This was a reasonable assumption in the circumstances.

Arrival of Schofields Pump 96 at about 4:59 am

145. At about 4:59 am Schofields Pump 96 arrived. It was crewed by Station Officer ("Station Officer") Brett Johnson, Firefighter ("Fire Fighter") Stephen Larkins, Fire Fighter Peter Bland and Senior Fire Fighter Glen Harris (driver/pump operator).

146. Station Officer Johnson was responsible for command and control of the scene. His duties included co-ordination and direction of Fire and Rescue resources and sending situation reports to Sydney Communications. Instructions were given face to face or via portable radios carried by the fire fighters. Station Officer Johnson retained this role until he handed over to Duty Commander West Glen Launton at about 5:35 am.

147. The work manual provided by Principal Healthcare states that one role of staff at a fire is to escort emergency services staff to the fire panel. It is not known whether or not staff were aware of this, but it did not happen. If it had happened, it is possible that the second fire, if already lit, would have been identified at that point. Instead, the fire fighters were taken directly to the first fire. None of the fire fighters inspected the Fire Indicator Panel. Station Officer Johnson subsequently stated that they had relied on the directions given to them by two female employees to locate the fire in ward 19.

148. Whether the Fire Indicator Panel would have indicated the presence of a fire in the A1 wing if it had been checked at that point in time is not known because records were unable to be recovered from it after the fire. Nevertheless, if it was functioning properly, and a fire was underway in A1 wing, it is probable that an examination of the panel would have disclosed the second fire at that time.

149. By this time, some of the residents from A2 wing had been evacuated by nursing home staff and were sitting under the awning outside the front entrance.

150. Helen Perry, who was in room 4 at the time, in her statement to police investigators says that some time after she first heard the fire alarm she was being escorted out of the wing by Roger Dean and she looked into room 3 and saw that Molly's bed was on fire (we understand Molly to be Mary Douglass) but that she was not in the bed. She says that she could see the foot of the bed through the doorway and that there were flames all over it. This raises a question as to the precise timing of the second fire being lit. It also suggests, however, that a second fire alarm would have been displayed on the Fire Indicator Panel if the LCD display had been examined.

Detection of the fire in the A1 wing

151. At about 5:01 am the CCTV captured smoke building up in the ceiling area in the front foyer. It appears to be coming from the direction of ward A1. In that segment of the footage, a resident is seen being evacuated from ward A1.

152. Shortly afterwards Station Officer Johnson can be seen on CCTV exiting the A2 wing into the front foyer. Station Officer Johnson had by that time directed Fire Fighters Bland and Larkins to extinguish the fire in ward 19 and he was heading to the fire truck to update Sydney Communications.

153. When he reached the front foyer he saw smoke issuing around the A1 wing's closed doors. He then realised that smoke was coming from a completely different wing. The CCTV footage shows him walking over to the A1 wing's fire doors briefly and then outside to Schofields Pump 96.

154. At about the time Station Officer Johnson was captured on CCTV making his way from the to the front entrance, a resident appears to exit the A1 wing doors into the front lobby. This appears to be Ms Bertha Leonard who had been in bed in ward 3, A1 wing, that night. Ms Leonard unfortunately suffers from dementia and has no recollection of these matters. The fire in A1 wing, however, was obviously well underway by this time.

155. Between about 5:02 to 5:03 am, Station Officer Johnson provided Sydney Communications an update and requested a "second alarm" be issued changing the designation from automatic fire alarm ("AFA") to a "structure fire". The second alarm was issued and caused fire trucks to be deployed from Riverstone, Kellyville, Seven Hills and Parramatta.

156. A second alarm does not indicate a second seat of fire. Rather it directs an escalation of resources. It does not appear that Station Officer Johnson investigated the precise source of the smoke coming from ward A1 at this point. Whilst it is not recorded in the fire log, it appears that at around 5.03 am Station Officer Johnson confirmed on radio communications that smoke was coming from two areas of the nursing home. This was sufficient to alert Sydney Communications that further resources were required.

Roger Dean exits the A1 wing

157. While Station Officer Johnson was at the truck, Mr Dean was captured on CCTV at about 5:03 am entering the front foyer from the direction of the A1 wing. The CCTV also captured Ms Helen Parry, a resident, walking closely behind him at this time. This is the first time he had been pictured on CCTV since he was seen leaving the front foyer to enter the A1 wing about eight minutes earlier.

Arrival of Blacktown Pump 63 at about 5:04 am

158. Fire Fighter Larkins extinguished the fire in room 19 and then opened windows to ventilate the room. On his account he extinguished the fire after having turned on the hose reel to cool fire gases in the room. Together with Fire Fighter Bland, he then commenced evacuating a patient from ward A2.

159. Blacktown Pumper 63, which was manned by Station Officer David McIlrath, Fire Fighters Barry Jones, Michael Watt-Seale and Heather Sutton, arrived at about 5:04 am. When they arrived, Station Officer Johnson tasked them for both fire attack and to remove persons from A1 wing. By around this time, the smoke was getting very thick as CCTV footage shows.

160. The crews of Schofields Pumper 96 and Blacktown Pumper 63 were the only fire fighters on scene for the next 13 minutes. Fire Fighters Larkins and Bland were working in wing A2, having extinguished the fire in room 19, when they heard on the radio a report from Blacktown Pumper 63 that a fire was 'ventilating'.[4] They thereby became aware of the second fire. They continued evacuating patients from ward A2 including one patient on a dialysis machine. Fire Fighter Larkins proceeded to evacuate all patients from the A2 wing before moving to assist other crews in A1 wing.

161. At about this time, Station Officer Johnson and Fire Fighters Jones and Watts-Seale (who were both wearing breathing apparatus) entered the front lobby together. Fire Fighter Jones took with him a charged 39 mm hose line, which was connected to the Schofields Pumper and had been laid out earlier by Senior Fire Fighter Harris. Station Officer Johnson directed Fire Fighters Jones and Watts-Seale into the A1 wing to commence search and rescue.

162. Station Officer McIlrath, meanwhile, was instructed to inspect the building to assess the situation and ensure evacuations were being undertaken. Station Officer Johnson remained at the front entrance to perform incident commander duties and later assisted with moving residents from the A1 wing out of the front lobby. Senior Fire Fighter Harris was positioned near the front entrance to assist evacuating residents. Fire Fighter Sutton was responsible for securing the water supply from their trucks. She positioned Pump 63 on Hambledon Road footpath to connect to a hydrant and secured water supply to P63 and P96.

Response of Fire Fighters between about 5:04 and 5:08 am

163. At around 5.04 am, Sydney Communications notified the incident commander that six appliances were on the way to assist the crews at the nursing home.

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[4] This means that the fire had broken out of the area in which it had previously been contained and gained access to additional oxygen, suddenly increasing its intensity.

164. Meanwhile, Fire Fighters Jones and Watts-Seale had entered A1 wing. They were confronted with dense smoke down to floor level throughout the ward and had zero visibility. Inside, some audible, moaning and coughing, but none visible, were many elderly residents trapped in the ward.

165. The heat in A1 wing was so intense that, despite his protective clothing Fire Fighter Watt-Seale had to drop to his knees near the doorway to ward 8 because it was too hot for him to stand. He had taken a Thermal Imaging Camera into the wing to locate the seat of fire but, because the heat was so great throughout the wing, the camera could not differentiate the seat of the fire from other hot areas.

166. As well as meeting fierce heat and impenetrable smoke, both fire fighters could hear, but could not see, a large fire burning overhead in the roof. Aware that there was an unknown but significant number of very vulnerable people in the wing, they made the immediate decision to find and evacuate the residents. Locating the residents was the first task. The fire fighters had to proceed by feeling their ways along the walls to beds to find the people. They commenced by evacuating residents from wards 7 or 8 into the front foyer. This was extremely difficult and required the fire fighters to improvise methods to remove the terrified residents. In some cases they attempted to wheel the beds out to but in others they were forced to drag the residents out along the floor wrapped in bedding. During this search and rescue operation, on a couple of occasions Fire Fighter Jones also reduced the heat by cooling the gases in the compartment by spraying water from the hose that had been inserted.

167. These two Fire Fighters repeatedly delivered residents to the front foyer and returned to the wing to rescue as many as they could. As the victims of the fire were delivered from the wing, Station Officer Johnson moved them to the front entrance. From there, staff and civilians assisted shifting the residents on to the grounds away from the entrance.

168. According to Station Officer Johnson, at some point (presumably after the evacuation of the A1 wing commenced), Fire Fighters Bland and Larkins confirmed to him that the room 19 fire was completely extinguished and asked for their next tasking. He instructed them to evacuate all persons from the A2 wing and to update him when that was done. He considered, at that time, there was significant enough smoke in that wing to warrant a complete evacuation. He was informed that some patients were attached to dialysis machines and he instructed that those residents be moved nevertheless.

169. At about 5:06 am Station Officer McIlrath, proceeded around the western side of the building near the outside of ward 4 of the A1 wing. He observed that the window of ward 3 was still intact but heavily stained. This indicated fire activity in that room. He also saw traces of smoke emerging through the roof and that the tiles above ward 3 were sagging owing to a loss of integrity of the supporting roof structure. He transmitted these observations via handheld radio to Station Officer Johnson.

The fire penetrates ward 3 window at about 5:08 am

170. At about 5:08 am the fire flared up through ward 3's window into the eaves of the building. Station Officer McIlrath notified Station Officer Johnson of this by radio.

171. At about the time of the flare up, Constables Kirsten Grech and Robert Johinke, followed by Sergeant Gregory Frail, arrived at the scene and began to render assistance with the evacuation. They were the first police on site. Constable Grech assisted moving residents out the front and flagged down drivers passing by on Hambledon Road to assist in doing so. She then entered and assisted evacuating residents from areas other than the A1 wing. Constable Grech was not wearing breathing apparatus.

Fire fighters' response between about 5:08 and 5:16 am

172. Back in A1 wing, Fire Fighters Jones and Watts-Seale were continuing to evacuate A1 wing. At this point, because priority was being given to the rescue operation, there was no active fire attack from inside the building. Fire Fighter Jones continued with evacuations until he had to leave to change his oxygen cylinder and then returned to the A1 wing.

173. On the western side of the building, Station Officer McIlrath opened the rear exit of the A1 wing, allowing thick black smoke to escape. He then donned an oxygen cylinder and breathing apparatus and returned to the rear exit which he propped open using a fire extinguisher. He then entered the western rear exit and evacuated a resident via the rear exit.

174. Like Fire Fighters Watts-Seale and Jones, Station Officer McIlrath also heard a lot of noise overhead due to fire activity in the roof space. A short time after entering the wing, he heard the ceiling partially collapsing.

175. Outside, Senior Fire Fighter Harris had been assisting evacuated A1 wing residents from the front foyer to the grounds and also with the pump. At about the same time as Station Officer McIlrath was observing the fire from the western side of the building, or shortly after Station Officer McIlrath had entered the wing, he noticed an orange glow coming from under the roof tiles adjacent to where the truck was positioned. He reported this by radio.

176. At around 5.15, as a result of flames being seen through the roof in ward A1, Station Officer Johnson directed Fire Fighter Harris to apply water from a high pressure hose reel to the roof. As he did not want to cause the roof to collapse on people in the wing, Fire Fighter Harris says he only applied a minimal amount of water. A short time later he observed a partial roof collapse. This was probably the same section that Station Officer McIlrath heard collapsing.

177. Station Officer Johnson escalated the response to a "Third Alarm" at 5:16 am. This resulted in fire trucks being deployed from Huntingwood, Mount Druitt, St Marys and Dunheved.

Arrival of pumpers from Kellyville, Riverstone and Seven Hills at about 5:17 am

178. At about 5:17 am fire trucks from Kellyville (P94) and Riverstone (P83) arrived at the scene followed closely by Seven Hills (P43). This significantly increased the number of fire fighters at the scene and who were available to assist with the A1 wing rescue and fire suppression operations.

179. As the Kellyville appliance pulled up, Fire Fighter Joseph Javillonar observed a fireball burst into the roof of the A1 wing. This may have been the ventilation of the fire that Fire Fighter Harris had seen. This indicated to him that the roofing was collapsing.

180. Station Officer David Castle and Fire Fighter Mark Fisher of Seven Hills Pump 43 entered the A1 wing together. They found the wing completely smoke-logged with very low visibility. When they reached the fire-affected room they realised that no one was actively hosing water onto the fire.

181. Fire Fighter Fisher located the hose line (probably the one earlier brought in by Fire Fighter Jones) and, realising that it could not reach because it was stuck in the fire door, released it and advanced it to ward 3. This was at around 5.26 am. He then spent approximately five minutes extinguishing the fire.

182. This was the first time that fire fighters take steps to extinguish or suppress the fire in room 3 itself. While doing so, he noticed that the roof and ceiling collapse of ward 3 had totally collapsed and also that the hallway ceiling had collapsed. The ceiling in ward 6 had partially collapsed.

183. Fire Fighters Jones and Watts-Seale were still evacuating residents from the A1 wing when the other crews arrived. According to Fire Fighter Jones, he was evacuating a resident from ward 6 when another Fire Fighter, whom he believed was from the Riverstone crew (P83), assisted him. This was the first time he had encountered another fire fighter other than Fire Fighter Watts-Seale. He estimated this to be about 17 minutes after his initial arrival.

184. After evacuating a resident from ward 6, Station Officer McIlrath again entered the A1 wing via the rear exit. On this occasion he took a hose line from Schofields' pumper and evacuated two residents from ward 5. Police were at the rear door by then and assisted by taking the elderly females to a location away from the building. Station Officer McIlrath was then assisted by a Kellyville fire fighter to evacuate a fourth resident.

Evacuations using the rear exit of ward A1

185. A ramp with a handrail at the rear exit of A1 wing made it virtually impossible remove bed via this route. While Station Officer McIrath was able to remove four female residents through that exit, he found that the railing of the ramp impeded the rescue of bed-ridden residents.

186. It is, however clear that a number of residents were removed using this exit which was to the far side of the fire in room 3. Fire Fighter Joseph Javillonar (Kellyville Pump) entered Ward 5 as well and extracted residents from that room out the rear fire exit. Two police officers stood outside the building and helped to bring the residents onto the car park to give them more space and access. Fire Fighter Dean Scifleet (Kellyville Pump) assisted Fire Fighter Javillonar in room 5 and also withdrew a resident from room 6 through the rear emergency exit. Fire Fighter Mark Fisher assisted to extricate a female resident through this door. Fire Fighter Bland assisted Fire Fighter Watts-Seale to remove a resident to the rear of the building at the car park. Constable Robert Johinke became involved with helping fire fighters evacuating residents from A1 wing via the rear exit. Constable Matthew Krauce and Constable Stephen Lewis also assisted in the evacuations via A1 wing rear exit.

187. After the collapse of the roof, Fire Fighter Barry Jones noticed a logjam of patients and one bed in the exit door. A number of fire fighters were working to clear the exit. He observed that a hose line had been brought in through the rear exit by Station Officer McIlrath.

188. As well as the problems with the ramp at the rear exit, fire fighters involved in evacuating A1 wing experienced significant difficulty wheeling beds out of that wing owing to roofing materials falling onto the ground and other debris that was in the way. It was also difficult to wheel beds over fire hoses. These difficulties will be considered further below.

Response beyond 5:30 am

189. At about 5:36 am Station Officer Johnson requested that a “Fifth Alarm” be issued. He handed over incident control to Duty Commander West Glen Launton at about this time. He, in turn, requested that the alarm be changed to a “Sixth Alarm”. This was done at about 5:37 am and resulted in more fire trucks being deployed to the scene. It appears, however, that by the time of the handover the fire in A1 wing was substantively under control and evacuations of that area were nearly complete. Numerous other fire trucks and other emergency personnel continued to arrive after that time.

190. A triage area was established outside on the grounds. Many residents received oxygen therapy and other treatment from fire fighters, ambulance paramedics, police officers and civilians.

191. Police Inspector Kenneth Schack-Evans arrived at the scene at about 6 am. He saw a large number of elderly patients lined up in the driveway and on the front lawn of the nursing home in hospital beds. He estimated there were approximately 75 police officers, 100 fire officers and 100 ambulance personnel at the scene at that time.

192. Numerous residents were transported to hospitals at Blacktown, Liverpool, Mt Druitt, Fairfield, Hawkesbury and at the Nepean and Royal North Shore Hospitals that morning.

193. Police officers were provided a list of residents and were tasked to attend all hospitals to identify which residents had been taken to what hospitals. Many of the residents who were less affected by the fire were also taken to the Uniting Church on Hambledown Road by bus.

194. After the fire was extinguished, the bodies of Ms Dorothy Sterling and Ms Dorothy Wu were discovered in their beds in ward 3. Ms Alma Smith, who had rescued from ward 5, was found to have died. It is not clear whether Ms Smith passed away whilst in the facility or shortly after the wing was evacuated.

The fire investigation

195. Inspector Robert Alexander, fire investigator, Fire & Rescue NSW, inspected Quakers Hill Nursing Home on 18 November 2011 and subsequently. The B1 and B2 wings were found to have suffered no fire damage and minimal smoke damage. Unsurprisingly, the A1 wing was found to have suffered the most damage including substantial roof collapse at the western end.

196. Inspector Alexander observed significant collapse of the gyprock ceiling in the hallway. He also saw beds against the rear exit at the western end of the A1 wing. Ward 3 was completely destroyed with the roof collapsed and burnt and damaged remnants of tiles and timbers were found in the room.

197. In the opinion of Inspector Alexander, the main damage to the ceiling plasterboard linings was from mechanical damage (i.e. roof tiles and timber impact) rather than thermal degradation to their bottom surface.

198. Broken glass from ward 3's window, located on the south wall, was found on the ground outside. The aluminium window frame was also found to have melted. The melting temperature of aluminium is 660 C.

199. Inspector Alexander concluded that the door to ward 3 had been open at the time of the fire. This was evidenced by the smoke trail through the corridor. The main thermal damage suffered on the corridor's upper wall and ceiling linings occurred immediately outside the doorway of Ward 3 where the fire vented.

200. The burn patterns on the ceiling joists within the roof space exhibited burning, deeper charring and bevelling on the upper surfaces indicating damage by a fire that had travelled laterally through the roof void from another area.

201. Regarding wards 4 and 5, Inspector Alexander concluded that the fire had spread from laterally through the roof void to those rooms.

202. Inspector Alexander considered how the fire had spread through the roof space. He was of the opinion that the fire caused the degradation of the window. After blowing out the window, the fire climbed to the eave, barge board and roof section immediately above the window, penetrating the roof space there and spreading laterally into other areas above the A1 wing.

203. A number of the fire fighters identified the sound of burning in the roof space shortly after their entry into A1 wing. This suggests that the fire was burning in the roof space from a very early stage in its development. This seems to contradict the hypothesis that the fire first penetrated the roof space from within ward 3 because the fire succeeded in degrading the gyprock ceiling lining or the ceiling collapsed under load from the timber and tiles or both. Questions raised by this evidence will be considered further below.

Fire research by Fire and Rescue

204. In December 2011 Fire & Rescue NSW carried out tests at the CSIRO. Four rooms were constructed to represent ward 19 and ward 3. The rooms' dimensions were exactly the same as the original although the construction methods differed from the original rooms. Furniture was also included in the rooms to match that in ward 19 and 3 on the day. (Of course, conditions could not precisely match those in ward 3 of the Nursing Home given that the test facility was not part of a larger building, and the door to the test facility opened to fresh air and not to the corridor of a nursing home.) Investigators assumed for the purposes of testing that the fire in the A1 wing burnt for about 24 minutes before it was extinguished.

205. In the first test, the bed located on the north east side of the room (replicating the location of Mary Douglass' bed on 18 November) was ignited halfway along the side of the bed. The fire developed slowly and gradually spread to the adjoining bed. About 10 minutes into development, the bed on the north west side of the room was then ignited as Inspector Alexander was of the opinion that the fire would not develop at all unless the second fire was ignited. The fire then gained momentum and developed into a fully involved fire. The maximum temperature reached during the 24 minutes duration was 1070 C.

206. In the opinion of Inspector Alexander, the fire in ward 3 must have originated from the western side of the room. That is a different position from that identified by Mr Dean in his interview. It is also not the bed that Ms Perry saw alight when she passed that room. If correct, it may mean that two fires were lit in ward 3, not just the one as claimed by Mr

Dean, or that when Ms Perry saw the bed alight as she went past ward 3 she was witnessing the fire spreading from elsewhere.

207. (Detective Sergeant Glen Morfoot, the Homicide Squad officer in charge of the police investigation, has a different theory based on the facts admitted by Mr Dean. Although from a criminal perspective the different theories may be academic only, from a fire perspective the question is more significant. This will be further discussed below.)

208. An identical room was then test-burnt (building B) to demonstrate the difference a sprinkler system would have made. It was dramatic and would have been life-saving had A1 wing been fitted with sprinklers. The test sprinkler activated after four minutes. The fire was confined to the bed of origin with minor smoke and heat damage to the room. The maximum temperature reached was 92 C.

209. A test was also undertaken concerning ward 19. This test proceeded on the basis that the fire was left unattended and the door not shut. The fire developed reached 439 C in 10 minutes and 40 seconds. Had Ms Watt not closed the door, the fire would have intensified with serious implications for safety of the A2 wing occupants and possibly others.

210. Questions remain as to the conclusions to draw from Inspector Alexander's tests. They will further considered below.

Examination of the Fire Indicator Panel

211. The Fire Indicator Panel was installed and maintained by National Fire Solutions Pty Ltd ("NFS"). The system is designed to log the history of alarm activations. However, when the Fire Indicator Panel was checked on 24 November 2011 no history log was found.

212. The Fire Indicator Panel was powered by Quakers Hill Nursing Home power with a battery back-up. Mr Ray Hicks, a fire alarm systems expert from NFS, offered the opinion that the power supply at Quakers Hill Nursing Home had been interrupted during the fire. This had caused the battery back-up to be activated. The nursing home's power remained interrupted for several days. In Mr Hicks's view, this had resulted in the back-up battery becoming exhausted causing the panel to lose power and the data to be lost. As a consequence, it is not known what time, if at all, the sensor activated in the A1 wing.

213. Fire Investigation Officer Graeme Moore inspected the Fire Information Panel on 18 November 2011 and observed that its text and indicators in the LCD showed:

"04:57:59 Smoke Alarm Akd 1 of 5

Z0001 Wards 9-22 Linen Closet."

214. This indicated that the first alarm activation, which was in zone 1 wards 9-22 Linen Closet, was acknowledged. It was consistent with five alarms being in alarm, with the first alarm having been acknowledged.

215. Whether Mr Moore would have been able to examine the log in relation to the alarms in A1 wing on 18 November is not clear. Certainly, the data were gone six days later.

The police investigation of Roger Dean

216. After he exited the A1 wing at about 5:03 am, Mr Dean was captured on CCTV walking to the B wing's nurses' station. He was recorded grabbing his yellow bag from that station. He was then captured on CCTV assisting residents in the B1 and B2 wing to evacuate. He was outside the building by about 5:07 am and was seen on CCTV to be assisting residents at various times on the driveway between about 5:09 and 5:57 am.

217. Mr Dean made a number of attempts to gain access to the Quakers Hill Nursing Home via the front entrance but was initially rebuffed either by fire fighters or police. On his last attempt, at about 6:08 am, Mr Dean succeeded in gaining entry. He spoke to Fire Fighter Gavin White and a station officer at the front entrance and stated that he had to get inside to get the "drug books". At this time, as far as fire fighters knew, he was merely a member of staff rather than a suspect or the perpetrator of the crime, the consequences of which they were fighting.

218. Mr Dean was escorted by Fire Fighters Scott Ashton and Gavin White to the treatment room attached to the B wing nurses' station. There he gained entry using using the treatment room keys he had in his possession and took the two drug registers from the Schedule 8 cabinet. He placed those in a yellow bag that he had taken into the room with him. He exited the building at about 6:11 am.

219. Having stolen the Schedule 8 drug register books, Mr Dean left the Quakers Hill Nursing Home on foot. As he left, he was stopped and interviewed on camera by a television news crew. That footage depicted him holding the yellow bag which contained the drug registers.

220. He then made his way to his home on foot. According to Mr French, his partner, Mr Dean arrived home about 6:30 am. Once home he ripped up the drug registers. Shortly afterwards he told Mr French that he had to return to the nursing home. Mr French offered to drive him. On the way, they stopped at Mr French's shop where Mr Dean dumped a plastic shopping bag containing the remnants of the drug registers into the Cheesecake Shop's bin. Mr French then dropped Mr Dean at the nursing home where he apparently stayed all morning until he was taken, at about noon, to Mount Druitt Hospital for treatment for possible smoke inhalation.

221. Police attended the hospital at about 2 pm and asked him to attend Mt Druitt Police Station to make a statement. He did so. The police took a typed statement in which Mr

Dean provided a false or misleading account about his duties and activities throughout the night. At that time, he made no admissions to lighting the fires or stealing Schedule 8 medication.

222. That evening, however, while a forensic procedure was being carried out, Mr Dean was informed by police that he was a suspect. He then told police that he had left something out of his statement concerning the fire and requested permission to speak to friends. After doing so, Mr Dean admitted to police that he had lit the fires and that he had used Ms Watt's cigarette lighter to do so.

223. Mr Dean participated in a lengthy electronically recorded interview with police that evening. He again admitted to lighting the two fires but he maintained his denial of the theft of the medication. When asked why he had lit the fires, he responded: "I'm just corrupted with evil thoughts that had made me do that" and that "…Satan saying to me that it's the right thing to do…".

224. On 21 November 2011 Police executed a search warrant on Mr Dean's home. Numerous items seized, including:

- two white cannisters labelled "*Rogers prescribed medication"* that were found to contain Endone tablets;
- boxes of Endone tablets (some empty)
- a blister packet of MS Contin[5] containing two tablets
- Zanax[6] tablets;
- "20 prescriptions in the name of Roger Dean"
- one clear box of various blister packets of tablets labelled "Rogers prescription medications".

225. In total 203 whole Endone tablets, 28 part Endone tablets and one Kapanol[7] capsule were recovered.

Dean's abuse of prescription medication and psychiatric status

226. It is clear from Mr Dean's medical records that he was regularly sourcing prescription medication from a range of different general practitioners during the time leading up to 17 November 2011. These GPs either had no knowledge or only imperfect and misleading information about prescription medication being sourced from other doctors by Mr Dean. During the period between April and November 2011, Mr Dean saw 10 different GPs and was prescribed medication by most of them.

[5] An opioid analgaesic.

[6] A sedative or anti-anxiety medication.

[7] A slow-release type of morphine.

227. Dr Michael Diamond, Consultant Psychiatrist, assessed Mr Dean upon the referral of the prosecution before he was sentenced and also testified in Mr Dean's sentencing proceedings.

228. During Dr Diamond's consultation with and assessment of him, Mr Dean detailed his history of prescription drug abuse. According to his self-report, his misuse of prescription medication commenced when he was working night shifts at the St John of God Hospital and working at the Hurstville Community Centre. It began when he was prescribed benzodiazepine for a physical condition and he began to take this medication for sedation and sleep.

229. Mr Dean said that, without disclosing that he was treated elsewhere, he had then begun to attend other doctors at a local medical centre to obtain more benzodiazepines. He reported that by about 2007 he was regularly taking benzodiazepines in the form of clonazepam and temazepam. This pattern continued after he moved to Quakers Hill and commenced seeing a new GP, Dr Asar, who treated him for depression and prescribed him antidepressants.

230. In Dr Diamond's opinion Mr Dean had a diagnosis of poly-substance abuse involving benzodiazepines, narcotics, antidepressants, antihistamines and psychostimulants.

231. In terms of Mr Dean's psychiatric functioning, Dr Diamond's observations and conclusions were in essence that:

- Mr Dean had never seen a psychiatrist for treatment or sought specialist assessment or treatment.
- Mr Dean did not suffer a psychiatric illness at the time of the offending. Specifically there was no evidence of Schizophrenia, Atypical Psychosis of any sort, Bipolar disorder, Major Depressive disorder with or without melancholia or Post Traumatic Stress disorder.

232. In Dr Diamond's opinion, at the time of the offending, Mr Dean suffered:

- Poly Substance Abuse,
- Adjustment disorder – Mixed Type Episodic[8], and
- Cluster B Personality disorder[9] – Mixed Type with narcissistic and histrionic features.

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[8] According the DSM-IV (the psychiatric diagnostic 'bible'), Adjustment disorder – Mixed Type Episodic is evidenced by the development of clinically significant emotional or behavioural symptoms after the onset of a stressful situation. The 'mixed type' involves emotional and behavioural manifestations of the disorder.

[9] Cluster B Personality disorder[9] – Mixed Type with narcissistic and histrionic features is not a "mental illness" that prevents people from understanding the meaning of their own actions and the gravity of them. The narcissitic element of the disorder manifests itself in behaviours characterised by a strong sense of entitlement to special recognition and treatment by others. They lack empathy, have fragile self-esteem and are often manipulative. The histrionic aspect is evidenced in a pattern of excessive emotion and attention-seeking. People with Cluster B disorders are dramatic, emotional and erratic.

Nursing staff concerns about Roger Dean

233. After these events, a number of the nursing staff expressed concern in relation to Mr Dean's performance, manner or behaviour at the nursing home in the period up to 17 November 2011. According to Ms Sidonia Thompson (AIN). From 5 October 2011 onwards Mr Dean would come to work with a blank face. She saw a thick build-up of white substance in the corners of his mouth. Ms Thompson suspected that it was from drug use. It is not clear whether she had this suspicion before the fire or whether it was a deduction that she came to after the event. In any event, her suspicions were not reported to management before the fire.

234. Ms Thompson outlined a number of odd incidents involving Mr Dean, including one incident concerning resident Ms Thelma Hodgson-Budd on 8 October 2011. In this case, Mr Dean woke a resident to give her Endone even though she had not asked for her medication. (Ms Thompson reported this to Ms Luneta Mateo). Police identified progress entries on 20 October and 3 November 2011 that may relate to this incident. Although it cannot be confirmed, Ms Thompson's observation raises the possibility that Mr Dean may have been medicating patients with a milder medication, such as paracetamol, in order to mask his own use of powerful medication such as Endone.

235. Ms Thompson told the police that Ms Mateo had admitted to her that she relayed to Ms Stofan the things that Ms Thompson had reported to her but that they had been desperate to find and keep a night RN and so had not acted.

236. According to Ms Lence Darley (AIN), soon after he started and thereafter she had seen something white in the corners of Mr Dean's mouth. In the week before fire, she noticed that he was somewhat dishevelled with one shirt button out and that his shirt was not buttoned up to match button holes. This was not reported to management. Ms Darley detailed numerous concerns about Mr Dean's competence up to 16 November 2011. She stated that she had spoken to Ms Thompson or Ms Watt about these concerns (but not to management). Her concerns included giving out medications to residents before they asked for it.

237. Ms Dawn McGee AIN also had concerns about Mr Dean's performance and competence before 16 November 2011. They included giving residents medication (i.e. panadol) when they had not asked for it so that he could then rest up and not worry about residents requesting it later on. She also said that he had been behaving in an erratic manner on 13 November 2011 including ranting about his landlord and debt and taking Mr Fahmi's blood sugar when Ms McGee attempted to change him.

238. According to Ms Virgie Quigg (AIN), she spoke to her friend Ms Michelle Matienzo who worked at a nearby BP Service Station, after the fire. They discussed Mr Dean frequently purchasing No-Doz tablets before the start of each night shift. Ms Quigg raised the possibility that Mr Dean had substituted No-Doz tablets for resident's pain medication. She recalled resident Ms Thelma Hodgson-Budd screaming in pain despite records showing she had been administered pain medication. Before the fire Ms Quigg did not report her concerns to management.

Sentencing of Roger Dean: admissions by Dean concerning the medications

239. Mr Dean entered pleas of guilt to eleven counts of murder and eight counts of recklessly cause grievous bodily harm. For the purposes of sentencing Mr Dean admitted that his intention in lighting the fires was to create a distraction to deflect management from further enquiring into the theft of the medication.

240. The sentencing judge, Justice Megan Latham, found that Mr Dean had intended to start a fire of substantial proportions that would either destroy the incriminating evidence in the treatment room (whether by fire or water damage) or create sufficient chaos to allow him to gain access to the treatment room in order to remove that evidence.

241. The magnitude of Mr Dean's drug consumption and the degree of impairment he suffered to his decision-making processes, particularly at the time of the fire, was the subject of some dispute at the sentencing hearing.

242. Although she accepted that Mr Dean had a poly-substance abuse disorder at the time the offences were committed, Justice Latham did not accept that his ingestion of drugs relevantly affected his capacity to form judgments and make calculated decisions in any relevant way. Her Honour expressed the view that if he consumed all medication as claimed he would have been in a stupor. All the evidence, however, especially the CCTV footage, demonstrates that Mr Dean was well aware of what he was doing at the time that the fires were ignited and the nursing home burning, as well as afterwards when he sought to dispose of the drug registers in the Cheesecake shop rubbish bin.

The structural fire inspection

243. Superintendent Christopher Jurgeit, Structural Fire Safety Unit manager, Fire & Rescue NSW, inspected the building after the fire. He found that the A1 wing fire doors had been largely successful in containing the fire to that compartment although the front foyer had suffered minor smoke and water damage.

244. He considered that the building had generally been kept to a reasonable standard but identified certain issues. Firstly, there was only one external fire hydrant positioned directly in front of the building's entry porch. In Superintendent Jurgeit's opinion that hydrant was not compliant with the relevant Australian Standard (AS 2419.1) despite being certified to be so in the building's annual fire safety statement dated 1 July 2011.

245. In Superintendent Jurgeit's view, that hydrant would not have provided sufficient coverage to the required areas within the building to comply with required standard. He stated that if there been compliant external fire hydrants at the southern (B1 and B2 Wings) or courtyard areas, fire intervention and suppression activities directed towards the A1 wing from those areas could have been taken more quickly.

246. A subsequent examination carried out by Fire Fighter Warrick Isemonger of the Fire and Rescue Building Compliance Unit also found that the hydrant's position was non-compliant. Absent other hydrants, to comply with the Australian Standard the hydrant was required to provide water coverage to all points of the complex. In fact, the coverage provided fell 11.4 metres short of the required coverage.

247. Superintendent Jurgeit was, however, unable to comment on whether the roof damage would have been eliminated if fire fighters had had the use of an external fire hydrant at the south of the property or from the courtyard. In his view the initial suppression activities from the exterior would have been delayed owing to the search and rescue activities being carried out within the building.

248. Secondly, Superintendent Jurgeit noted that the integrity of the separate fire compartments within the ceiling void had been potentially compromised by the incorporation of timber elements that penetrated the firewall. Those timber-penetrating elements were not roof battens and were coated with an unknown material for a distance of about 500 mm from the points at which they penetrated the firewall. Superintendent Jurgeit was unable to be sure whether the timber penetrations were effectively fire-resisting.

249. The principal concern in this regard is that had the fire in the A1 wing spread to the wall adjoining the office and front foyer area, the integrity of the fire wall may have been jeopardised and allowed the fire to spread throughout the building through the roof space. Fortunately, the severe fire damage he observed in the roof space was a small distance from the fire separation wall.

250. Thirdly, the external ramp and associated balustrade that connected the A1 Wing's western exit to open space incorporated a 90 degree turn. That ramp and its turn did not permit beds to be wheeled down the ramp and away from the building. It appears to have obstructed or hindered safe egress from A1 wing for patients who were bedridden. During his inspection on 18 November 2011, Superintendent Jurgeit observed an empty bed in the corridor near the exit door.

251. It is difficult to be sure when that ramp was added to the exit door from ward A1. It appears to be included as part of the "as is" plan when some further proposed alterations (which did not eventuate) were drawn in 1998. At that time, the owner of the site was listed as Moran Health Care Group. However, none of the fire evacuation plans include any reference to the ramp.

252. Fourthly, apart from the ramp design, Supt Jurgeit believed that the evacuation had been hindered by roof debris falling into the corridors and the fact that there was insufficient room to turn beds around corners of the exit ramp. This resulted in beds being abandoned in inconvenient places and necessitated patients being physically carried or dragged out of the building, a slow, inconvenient and somewhat hazardous process.

Mandatory requirement for fire sprinklers in NSW aged care facilities

253. On the 1 January 2013 new laws were introduced to require the installation of fire sprinkler systems in all existing Commonwealth-accredited residential aged care facilities in NSW. The installation of fire sprinkler systems is to be completed no later than 1 March 2016. All new aged care facilities built after 1 January 2013 require the installation of fire sprinkler systems.

254. This change has been effected, in large part, through an amendment to the *Environmental Planning and Assessment Regulation 2000*. It was implemented after significant consultation.

Issues investigated

255. To enable me to address the broad statutory questions I am required to investigate under the *Coroners Act*, the following more specific issues were raised by Counsel Assisting:

- The causes of death (where in doubt) of Joan Joy, Emmanuela Cachia and Esther Newham.

- In relation to Roger Dean's employment at the Quaker's Hill Nursing Home:

    a. Were there incidents of concern in Roger Dean's employment history prior to his recruitment at Quakers Hill Nursing Home and should these have been reported?

    b. What screening was available and/or carried out by Quakers Hill Nursing Home at the time of his recruitment and the appropriateness of this?

    c. Were there any incidents of concern in his Quakers Hill Nursing Home employment prior to 16 November 2011? If so, were those adequately notified and managed?

    d. Was the response of management to the suspected theft of medication on 17 and 18 November 2011 reasonable and appropriate?

    e. Was appropriate training given for dealing with suspected misconduct?

- How did Roger Dean ignite the fire in ward 3, A1 wing, and how did that fire spread?

- In relation to fire safety design features of the Quakers Hill Nursing Home:

a) What were the applicable standards for those features and how did they compare to the standards that would have applied had the development application for the construction of Quakers Hill Nursing Home been approved as at 18 November 2011?

b) What were the fire safety design features of wing A1 as at 18 November 2011, including but not limited to: the fire rating of windows, ceilings, and the roof; egress; fire doors; and the fire compartmentalisation of the wing and was there compliance with applicable standards and/or requirements?

c) Was compliance with the applicable standards checked and maintained?

- In relation to the fire protection equipment and fire safety training of staff at the Quakers Hill Nursing Home:

a) How did the fire indicator panel operate as at 18 November 2011 and would it have adequately alerted AHNH staff and Chubb Security to the presence of the fire in A1 wing (as distinct from the fire in A2 wing)?

b) What training had Quakers Hill Nursing Home staff received regarding the use of the fire indicator panel and evacuation procedures for the Quakers Hill Nursing Home prior to 18 November 2011 and was this adequate?

c) Did the number and positioning of fire hydrants and fire hoses on 18 November 2011 satisfy the applicable requirements?

d) Was compliance with the applicable standards appropriately checked and maintained?

- In regards to the response of firefighters:

a) Would the fire indicator panel have specifically alerted firefighters, upon their initial attendance, to the presence of the fire in A1 wing? Was it checked?

b) What steps were taken by firefighters in regards to the detection of the fire in the A1 wing, and the evacuation of residents and the suppression of the fire in that wing?

c) Was the command and control of the firefighters response appropriately managed and was communication adequate?

- What, if any, lessons can be learnt from this incident?

Issue 1: Emmanuela Cachia, Joan Joy, Esther Newham -- causes of death

256. In relation to Emmanuela Cachia and Esther Newham, issues arose as to whether or not the fire on 18 November 2011 caused or contributed to causing their deaths. In relation to the death of Ms Joan Joy, there was a question as to the cause of death and as to the appropriateness of medication prescribed prior to her death.

257. Professor Jo Duflou gave evidence during the hearing concerning the deaths of Ms Cachia and Ms Newham. In relation to the death of Ms Cachia, he supported the finding of the forensic pathologist who had conducted the autopsy, Dr Matthew Orde, that the most likely cause of her death was sepsis (an acute systemic infection) the source of which was unidentified but which led to multi-organ failure.

258. In Dr Orde's report, he stated that in his opinion, the fire had not contributed significantly to Ms Cachia's death. Professor Duflou, however, who had access to medical records that Dr Orde had not had an opportunity to consider at the time of the autopsy, thought that it was more likely than not that smoke inhalation and hot gases generated by the fire had accelerated Ms Cachia's deterioration.

259. He reached this conclusion on the basis of three main factors: first, before the fire, her lungs were in a comparatively reasonable condition. After the fire, they were generally worse and she never fully recovered her pre-fire condition. Second, in his view, the sepsis was most probably caused by an antibiotic-resistant hospital-acquired infection. She was in hospital because of the fire, so became infected indirectly as a result of the fire. Third, the deterioration in her condition following the fire was mainly in the lungs. A relatively minor physical insult can have a disproportionate effect on an elderly person whose general health is poor as it was in Ms Cachia's case before the fire.

260. Although the direct evidence that the fire was a significant cause of Ms Cachia's death is not strong, the circumstantial evidence, particularly coincidence of Ms Cachia's decline in respiratory function and her exposure to smoke and hot gases during the fire, suggests that it is more likely than not that the fire made a material if unquantifiable contribution to her death. This conclusion is supported by the other factors mentioned by Professor Duflou.

261. Ms Newham was 102 years old when she died on 19 December 2011. Although she had been exposed to some smoke, she received no burns and no evidence was found of any persistent or consequential damage to her lungs as a result of the fire. In Professor Duflou's opinion, she most likely died of 'extreme old age' or natural causes, there being no single disease that could be diagnosed as causing her death.

262. In relation to Ms Joy, the question raised by the autopsy was whether her death had been caused or accelerated by medications administered to her after the fire. She had been treated at the home on a dialysis machine. To evacuate her from the home, the machine had to be disconnected. She was subsequently treated in hospital before being discharged to another nursing home. She died on 4 December 2011. The forensic pathologist who examined her body, Dr Rebecca Irvine, found her to be suffering multiple co-morbidities but no demonstrable acute cause of death.

263. Dr Irvine found as well that Ms Joy had significant concentrations of a number of medications in her system at the time of her death. They included morphine, paracetamol, metoclopramide (used for nausea and gastrointestinal conditions), and clonazepam. She also found a modest concentration of sertraline (anti-depressant). Dr Irvine therefore raised the question whether these medications may have accelerated Ms Joy's death and recommended that an opinion be sought from a forensic toxicologist.

264. Evidence was given at the inquest by Professor Kennedy. Of the drugs found, he considered only the morphine and metoclopramide as having possible significance in relation to Ms Joy's death. He said, however, that calculation of ante-mortem concentrations of the medications in her blood was not possible due to redistribution of drugs that occurs once the blood stops circulating and due to movement of the body after death. In his view, both drugs were likely to have worsened her condition before her death, especially the nausea, vomiting and respiratory distress she suffered shortly prior to her death. Beyond this, however, he could not offer an opinion.

265. Ms Joy was an elderly and seriously ill patient with poly-system disease. It is not possible to identify any one mechanism that caused her death. There is no compelling evidence that her medications contributed in any significant way to her death. It is more probable than not that a combination of natural causes, including kidney disease, heart disease, chronic lung disease and gastrointestinal disease, brought about her death.

Issue 2: Roger Dean's employment and performance at Quakers Hill

266. There is clear evidence of incidents of concern in Roger Dean's employment history prior to his recruitment at Quakers Hill Nursing Home. In particular, his behaviour and use of drugs at the St John of God Hospital in 2011 had direct relevance to his subsequent conduct at Quakers Hill when he was seen in an obviously drug-affected condition at work in mid-2011.

267. At the time, management of the St John of God Hospital was told by Mr Dean that he suffered bipolar disorder and that he was being treated by a medical practitioner.

268. Although the *Health Practitioner Regulation National Law (NSW) 2009* requires employers to notify the Australian Health Practitioner Regulation Agency if it reasonably believes that a nurse has been working professionally while intoxicated by drugs or alcohol[10], Mr Dean's explanation that he was, in effect, suffering the side-effects of prescribed medication misled Mr Dyer, the director of nursing. Dr Diamond's diagnosis of a Cluster B personality disorder with narcissistic and histrionic features had not been made at this time but Mr Dean appears to have exercised his tendencies to use emotion in a manipulative fashion to deflect and mollify Mr Dyer's concerns and suspicions.

269. The mandatory notification of drug intoxication when health professionals are practising their professions is part of a national regime intended to protect patients and the wider public from harm. Notification under the Act has potentially very adverse consequences for health practitioners. The system is intended, among other things, to operate fairly and in the least restrictive way 'necessary to ensure health services are provided safely and are of an appropriate quality'.[11] Most fair and reasonable employers and supervisors like Mr Dyer are, no doubt, reluctant to make reports to AHPRA unless they believe that they have strong grounds for doing so.

270. Nevertheless, with hindsight we can see that there may have been an opportunity to diagnose and address Mr Dean's polysubstance abuse issues before he caused the harm he ultimately inflicted on his victims. Moreover, a mandatory notification to AHPRA may have resulted in deregistration or limited registration being imposed on Mr Dean.

271. Unfortunately, another opportunity was lost when Mr Dean applied to work at Quakers Hill. Because, it seems, the nursing home was desperate to fill the vacancy for a night shift Registered Nurse, virtually nothing was done to check Mr Dean's bona fides except to ensure that his registration was current.

272. Even the timeworn references that he provided went unchecked. Ms Stofan's explanation for this is that she expected little from referees except uncritical endorsement of the prospective employee. She preferred to test the new employee on the job. While her cynicism in this respect may have had some justification – references by past employers are notoriously variable in quality and sometimes very misleading - it is difficult to believe that if she or someone in the management hierarchy had pressed Mr Dean on his previous employment and discovered his history at the St John of God Hospital by talking to Mr Dyer, they would not have placed confidence in his claims of professionalism and suitability for this job. The

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[10] Section 142(1)

[11] Section 3(3).

Quakers Hill management would also undoubtedly have been concerned about his deception.

273. Discussion with previous employers, such as the St George Hospital, may have led to the discovery of Mr Dean's concealed employment at the St John of God Hospital. When examined about these matters during the inquest, Ms Stofan admitted significant shortcomings in the process of checking Mr Dean's work history.

274. Further opportunities to uncover Mr Deans's drug abuse behaviours and take action were also missed once he began work at Quakers Hill. As we have seen, nursing staff observed and even reported a number of incidents that concerned them. Until the night when police were called, the most worrying, had full attention been given to it, should have been the incidents in which he was seen to be waking up patients to give them medication they had not requested.

275. Unless specifically charted by a medical practitioner such conduct should, indeed, cause misgivings and suspicions because the administration of such drugs is not or does not appear to be needed and therefore should not be given. It is self-evident that such behaviours may indicate that the uncalled-for medication of patients is being used to camouflage self-medication by a nurse with access to, and a dependency on, drugs of addiction.

276. Various physical observations made by nursing staff were also made that, if managed differently, might have resulted in a closer investigation of his behaviour by management. They included sighting of white substance in the corners of his mouth; occasions on which he appeared dishevelled; erratic and other behaviours that caused staff to question Mr Dean's competence; and the purchase of No-Doz tablets.

277. At least some of these concerns had been reported to Ms Mateo and Ms Stofan, including, extraordinarily, an allegation that Mr Dean would sometimes disappear for hours while he was meant to be on duty, claiming that he was 'owed' hours of time.

278. These behaviours were not interpreted or understood by staff at the nursing home as signs of possible drug addiction. The nursing staff received no specific training in detecting signs of drug intoxication or addiction in professional colleagues. And, no doubt, if they had suspicions they were hesitant to draw damning conclusions on the basis of ambiguous evidence that they did not fully understand.

279. In my view, this case demonstrates the desirability of nurses and health professionals receiving routine in-house training concerning the potential misuse of drugs by members of their professions, the signs of impairment due to drug misuse or dependency, and the procedures for reporting any concerns or observations that might reasonably indicate that a nurse or other health professional is adversely drug-affected.

280. It also demonstrates the need for nurses and other health professionals to be educated as to their responsibilities concerning mandatory reporting of incidents involving nurses and allied professionals working while apparently intoxicated by drugs.

281. Finally, it demonstrates the need for those administering nursing homes (and other organisations in which nurses are employed) to develop and put into practice clear and simple standard operating procedures or protocols for the investigation and management of suspected cases of nurses and other health staff working while drug-intoxicated. In particular, the protocols should be designed to ensure compliance with the *Health Practitioner Regulation National Law (NSW) 2009.*

282. Although Mr Dean's extreme response to the discovery that large amounts of Schedule 8 medications had gone missing could never have been anticipated by management of the nursing home, the failure to remove him from the nursing home and suspend him from duty pending the outcome of the police and internal investigations was a lame and risky response.

283. At the very least, management could and, in my opinion, should have foreseen that a person in Mr Deans's position might seek to tamper with or destroy vital evidence especially as, once Ms Mateo left the building, Mr Dean, being the only Registered Nurse in the complex, had possession of the treatment room keys. It could also have been foreseen that if he had stolen Schedule 8 drugs he may be drug-affected and pose a risk of harm in some fashion to patients and possibly staff. And it could have been anticipated by management that Mr Dean may seek retribution against staff members whom he believed or suspected had reported his activities in the treatment room or to intimidate them to prevent them giving evidence against him to the police.

284. In my view, Ms Mateo should have been empowered either to suspend Mr Dean immediately on the night of 17/18 November or at least to send him off the premises until he was permitted by senior management to return. Alternatively, Ms Stofan, who was apprised of the facts and allegations, should have suspended Mr Dean on the spot once she had been briefed by Ms Mateo.

285. The general hesitancy among staff members, from Assistants in Nursing up to Ms Stofan, to take prompt and decisive action to quarantine a nurse acting suspiciously and possibly dangerously, establishes the need for clear protocols and well-understood principles emphasising the primacy of risk-management and prevention of potential harm to vulnerable patients and other staff members. It would be surprising if this lack of preparedness at Quakers Hill on the dreadful night of 17/18 November 2011 was not symptomatic of an issue that need to be addressed throughout the industry.

286. Unfortunately, in this case, no cogent explanation for leaving Mr Dean on duty and in charge at the nursing home was provided by Ms Stofan. Given the late hour, tiredness and lack of experience in dealing with such an issue, and her belief that the issue would be resolved in some way when the police returned in the morning, almost certainly impaired Ms Stofan's judgment. It may also have been that her holiday plans also affected her decisions not to attend the nursing home in person and to send Ms Mateo home. If so, this underlines the need for clear guidelines and protocols.

287. This error was compounded by leaving Mr Dean in possession of the treatment room keys. It is astonishing that he was allowed to control both the treatment room and the Schedule 8 drug cabinet keys, especially after his conduct had resulted in the police being called to investigate. To allow any staff member to have sole access to Schedule 8 drugs at night was very lax management practice. One of the keys could have been left in the possession of the senior Assistant in Nursing or another trusted employee.

288. If it was thought necessary at all for nursing staff at Quakers Hill to have access to Schedule 8 drugs at night – in a nursing home this is not a self-evident proposition in itself unless palliative care is being administered – two members of nursing staff should have been required to be present whenever the Schedule 8 cabinet was opened. The Schedule 8 drug protocols applying under the *Poisons and Therapeutic Goods Act 1966* and *Regulations 2008* (NSW) are, among other things, intended to prevent the kind of conduct in which Mr Dean engaged at the Quakers Hill Nursing Home. But they rely for their efficacy on sound management practice.

289. Finally, while Mr Johnson, the senior executive consulted by Ms Stofan, could never have foreseen Mr Dean's actions, he too does not seem to have acted urgently to suspend or at least remove Mr Dean from the premises. While it is understandable that he was prepared to allow Ms Stofan and the police to carry out their investigations, the fact that a Registered Nurse suspected of stealing large amounts of Schedule 8 drugs may constitute a danger to patients and staff does not seem to have been given prominence in his thinking. If any further demonstration of the necessity of strict and clear protocols for dealing with such incidents and suspected incidents is needed, this is it.

Issue 3: Ignition and Spread of the Fire

290. As noted above, there is a difference of opinion among the investigators as to whether Mr Dean lit one or two fires in A1 wing. Mr Dean admitted to lighting only one bed whereas some of the evidence produced later by physical testing suggests that another was lit. In my view, the only clear evidence is that he lit at least one fire in a bed in the north-east corner of Ward 3. Ultimately, it is immaterial whether he ignited one or two beds.

291. A question of whether fire safety design also contributed to the spread of the fire is dealt with below.

Issue 4: Fire Safety Design at Quakers Hill Nursing Home

292. The basic fire safety standards applying to the nursing home in 2011 had been set at the time of its construction in 1981 under the provisions of Local Government Ordinance 70, the *Private Hospitals Regulations 1955* and the 'Hosplan Planning and Design Note, Fire Protection of Health Buildings'. That regime was replaced by the *Building Code of Australia and the Environmental Planning and Assessment Act 1979* and the *EPA Regulation 2000*. In essence, the Building Code and EPA Act and Regulation simply affirmed the 1981 standards in almost all respects. As a general rule, owners of buildings do not have to keep meeting new and higher standards as they develop over time.

293. Nevertheless, by 2011 a number of enhancements had been made to the Quakers Hill Nursing Home to improve fire safety. They included the installation of smoke alarms, 'fail-safe' fire doors, a Fire Indicator Panel and compartmentalisation of the complex to reduce risk of fire spreading from one area to another.

294. At the time of the fire, each wing of the building constituted a single fire compartment, separate from others. At the main entrances of each wing, fire doors had been installed. They closed automatically when a fire alarm was activated. The doors were designed to contain a fire within the compartment for long enough to allow fire fighters to engage and extinguish it before it spread to other compartments. On 18 November 2011, the doors and wing compartments functioned as intended.

295. Each individual room or ward was also designed and intended to operate as a stand-alone fire compartment. The gyprock ceiling was rated to withstand heat up to 490°C for an hour. Aluminium window frames degrade to melting point at 660°C. The successful containment of the first fire Mr Dean lit, in Room 19 in A2 wing, demonstrated the general effectiveness of this design feature provided that the door to a room was shut. One of the major differences between the fires in A1 and A2 wings was that the door to Ward 3 remained open, allowing oxygen to fuel the fire within it, whereas the door to Room 19 was shut as soon as a nurse saw it.

296. A question remains, however, whether the fire safety design features all worked as designed. That question arises, in particular, because some of the fire fighters recalled, from an early point in time, hearing crackling in the roof space. If the mechanism by which the fire moved into the roof space involves the fire first reaching such a degree of heat intensity that the window frame melted, and the fire then rising to the eaves and then into the roof space, that would suggest that there should not have been fire in the roofspace in the early phases of the fire's development before the window blew out.

297. Moreover, the CCTV footage would indicate that the fire breached the window in ward 3 at around 5.08 am. That is some five minutes after Fire Fighter Jones and Watts-Seale appear entered ward A1 and heard a fire overhead. The obvious conclusion to draw is that the fire had penetrated the roof space before the window blew out. This suggests either that the fire rose well above the temperature at which fire-rated gyprock degrades much more quickly than the tests indicated or that the roof space was penetrated because the integrity of the gyprock barrier had been compromised. Which is the more likely I am unable to say.

298. A retrograde and apparently unauthorised design feature of the nursing home was the ramp at the rear exit of A1 wing. As has been discussed, this proved to be a significant hindrance to the efficient evacuation of bedridden patients from the building especially once further obstacles, such as smoke, hoses and debris added to the difficulties of the rescuers. How this potential hazard was not identified in fire inspections and audits before 2011 is difficult to understand.

299. The explanation may be that the culture of auditing focusses attention on legal compliance with certain requirements rather than with mindfulness of risk and identification of potential hazards. This can result in a 'tick-a-box' approach to safety auditing.

300. As I have remarked in another inquest concerning an industrial explosion and deaths:[12]

> *An emphasis on compliance and regulation of safety can, paradoxically, reduce safety. [Safety audits] can be seen … as a form of regulatory homework rather than as a tool for improving the actual safety of staff and others… In short, compliance (insofar as that went) rather than mindfulness of risk itself seems to have been uppermost in the minds of those operating and working in the winery… The reason for this is probably that past experience had suggested that there was little or no actual risk.*

Issue 5: Fire safety equipment and training at Quakers Hill

301. The Fire Indicator Panel at the nursing home was in working order and enabled staff to identify the first fire Mr Dean had lit. Smoke sensors activated the alarm and the panel also alerted the alarm company and Fire and Rescue.

302. The nursing staff were trained to respond to an alarm by checking the Fire Indicator Panel to locate the fire, closing doors in the room in which a fire had commenced (after rescuing any patients) and notifying Fire and Rescue. They followed their training

[12] *Inquests into the deaths of Trevor Drayton and Edgar Orgo & Inquiry into explosion at Draytons Winery, Pokolbin* 13 July 2011 at [85]-[88].

correctly in dealing with the first fire. They also removed patients from A2 wing as a precautionary measure. Again, this was good practice.

303. The staff identified the first fire correctly using the Fire Indicator Penal. Although the panel could have been further interrogated by nursing home staff scrolling down through an LCD panel, that was not done. Had the panel been designed differently with all areas of the complex displayed on the board, it may have disclosed at that time or a little later that a second fire was underway in A1 wing. The staff made the reasonable assumption, as did the fire fighters when they arrived, that there was only one fire and that it had been identified and located.

304. Fire Indicator Panels are not built to a uniform design. One lesson that might usefully be learned from this experience is that the panel should indicate all areas that are on fire without any further steps having to be taken by those investigating alarms.

305. Except, of course, in the case of deliberately-lit fires being ignited, it is highly unusual for two fires to break out in a building in different locations simultaneously. The nursing staff and fire-fighters had no reason at the time of the first alarm to believe that anyone had deliberately lit the fire. I, therefore, make no criticism of the nursing staff or fire fighters for not checking the panel further than they did.

306. Conflicting evidence was given by various witnesses from the nursing home staff as to their training in withdrawing non-ambulant patients from fire zones. Some had been trained in using blankets or bedding as a sort of sled in which patients could be dragged to safety. Others were unaware of this technique.

307. It is well known by adult educational experts that skills [such as rescuing people in emergencies] are best taught using a combination of theory and practice. Common sense and relevant experience can be a substitute for practice of particular skills up to a point but effective skills training ought not be confined to classroom lectures. Numerous educational studies have demonstrated that only about five per cent of lecture content is retained by audiences unless they also practise the skills being discussed.[13] A 'learning-by-doing' approach has been found to be about 70 per cent more effective. Employers who merely subject their staff to professional development lectures are likely to be wasting their money and their staff members' time.

308. Evidence was given that a contractor had provided staff with theoretical instruction in removal of patients in the case of emergencies. The training did not, however, include practical exercises. On the night of the fire, however, those staff who were engaged in evacuating the building of patients appear to have done so efficiently and with proper care of their fragile patients. I note, however, that in NSW Health facilities it is the norm that a practical exercise in evacuating buildings is conducted annually. This appears to be current best practice. In my view, it ought also be standard practice in nursing homes.

[13] See, for example, http://thepeakperformancecenter.com/educational-learning/learning/principles-of-learning/learning-pyramid/ accessed 05 March 2015.

309. Similarly, further thought needs to be given to the question of the optimal method of removing bed-bound patients, and other vulnerable patients, from nursing homes and similar facilities, such as hospitals, in emergencies. Fire and Rescue's view appear to favour moving beds rather than dragging patients along floors. Where this is practicable, this appears to be the best method both because hospital beds are designed to be moved easily and efficiently and because keeping a patient in bed minimises the risk of injury during an evacuation .

310. The one main flaw in the response of the nursing staff was overlooking the need to call '000' as well as letting the automatic fire alarm notify Fire and Rescue. After the initial alarm, Fire and Rescue received no further information from nursing staff. The post-fire analysis by Superintendent Gordon Boath of Fire and Rescue noted, 'A "000" call to the ComCen to reveal the situation would have generated a weight of attack commensurate with the realistic potential of the incident as may have been described by the staff."[14]

311. The nursing home's evacuation plan that was set out on the nursing home wall near the Fire Indicator Panel clearly sets out that a call to '000' should be made. It seems that the senior nurse on duty has responsibility for making the call. Other staff presumed that the senior nurse would do this. Mr Dean was no doubt thinking about other things at the time.

Issue 6: Response by Fire and Rescue NSW

312. On the night of the fire, the response of NSW Fire and Rescue was exemplary. While it is true that the fire fighters did not check the Fire Indicator Panel on arrival as they would ordinarily do, this was, as I have discussed above, because they reasonably believed that there was only one fire and that it had been located by the nursing staff. It was not until smoke was seen issuing from A1 wing that anyone realised that a second fire was burning. It is not possible to determine whether an examination of the Fire Indicator Panel when the fire fighters arrived at 4.59 am would have revealed that a second fire was blazing in another wing. I make no criticism of the fire fighters who went directly to the fire as their training had educated them to do.

313. Once the discovery of the second fire was made, however, the response of the fire crews was immediate and appropriate. While the conduct of all the involved fire fighters was commendable and even heroic at times, the coronial team and I developed particular admiration during the inquest for the work of Fire Fighters Jones and Watts-Seale and Station Officer McIlrath who laboured in exceptionally hostile and extreme conditions to find and rescue patients in A1 wing.

314. During the hearing, Fire Fighters Watts-Seale and Jones gave what seemed to lay people to be extraordinary evidence. As I have described earlier, the heat was extraordinary and

[14] Operations Post-incident analysis: Quakers Hill Nursing Home Fire. Annexure B to the statement of Assistant Commissioner Brown (volume C4 of the coronial brief) p.63 [18.1.3]

probably reached over 1000° C in ward 3 at its peak. It is difficult to imagine more challenging conditions for a search and rescue operation than those that confronted the two first fire fighters to enter A1 wing: dense smoke; almost overwhelming heat; a fire in the roof likely to collapse and an unknown but significant number of victims to rescue from an unfamiliar building.

315. Something of the magnitude of the task, and the professionalism and humanity with which the two fire fighters worked desperately to save lives in A1 wing, was perhaps illustrated in one of the few light moments during the inquest when the following exchange took place:[15]

Q: Officer Watts-Seale, … I'm trying to imagine this, but I suppose you must have felt very worried when you heard the fire in the roof, did you?

A: Yes, your Honour.

Q: And what was the particular worry you had?

A: I knew that the fire would be difficult to access and at some stage the roof would collapse, your Honour.

Q: And what did that lead you to think then?

A: That we had to evacuate people very, very quickly before the roof collapsed.

Q: Were you worried about the roof falling in on you?

A: Not personally.

Q: What about other fire fighters?

A: No.

Q: If the roof had fallen in on you or other fire fighters… well, some people might think you are supermen, but I'm assuming that a few tonnes of tiles and things on your shoulders would not be something you'd just brush off, despite your equipment?

A: It's not unusual to have the roof collapse on us when we're in a structure fire, no, your Honour. It may hurt but it rarely injures us because the tiles seem to fall separately and they bounce off your helmet and shoulders and otherwise it's plasterboard and maybe a piece of wood or two.

Q: I see, well, you are supermen. I'm amazed…

316. While there were numerous individual acts of heroism and humanity, it must also be observed that the control and command exercised by senior fire fighters at the scene was also of a very high standard. The circumstances encountered by Station Officer Johnson were extreme, dynamic and highly unusual.

317. On the way to the fire, he had expected to be dealing with either a false alarm or at most one fire only. The scale of the challenge he and his crew faced was imperceptible to them

[15] Transcript 11 September 2014 p.11

at that stage and on their arrival. Given that he and his crew were the first arrivals and did not have support for some little time afterwards, it was heightened by the fact that Station Officer Johnson had both to control the operation and engage in active duties inside the building.

318. All the while, he was receiving information from fire fighters in both A1 and A2 wings, from pumpers outside the building, from Sydney Communications and about nursing staff and their efforts to remove patients from the building. He was also co-ordinating and allocating more crews as they arrived and trying to assess the location, extent and intensity of the fire as it developed. He retained command of the operation until relieved by the arrival of a more senior officer as the scope of the operation expanded.

319. One of the difficulties that Station Officer Johnson and the fire fighters had to deal with on their arrival was a paucity of accurate information about what was going on in the complex. Not only were they unaware of the situation in A1 wing, they were also unaware of how many patients in the A2 wing had been affected by the fire in that wing. Once the evacuation of A2 wing had commenced it had to be completed. This meant, however, that Fire Fighters Jones and Watts-Seale were attempting to reconnoitre the A1 wing by themselves and make choices about whether to fight the fire or remove patients. Ideally, they should have been given more support earlier. In saying this, however, I make no criticism of the Incident Controller. The cliché of 'the fog of war' obscuring the battlefield is very apt this case. Station Officer Johnson and the fire fighters in A1 wing were literally blinded by the dense volumes of smoke.

320. Assistant Commissioner Mark Brown commented at the inquest , '*I've often thought about what I would do in those circumstances and I'd like to think I would have acted as well as they did and made the decisions they did because I think they actually did a pretty good job*.'[16] Coming from a very experienced senior officer, that comment spoke volumes about the courage and professionalism of those crews. I can only endorse his sentiments. The fire fighters, police and others have received commendations from the Commissioner. In addition, I propose to nominate Fire Fighters Watts-Seale and Jones and Station Officer McIlrath for Australian Bravery Awards.

Lessons learned

321. NSW Fire and Rescue has a unit dedicated to analysing fire and learning lessons from them. Perhaps the most important lesson this fire taught us was that all nursing homes and similar facilities should have fire sprinkler systems installed. Had a sprinkler system been operational at Quakers Hill on 18 November 2011, the loss of life would have been far reduced and possibly averted entirely and injuries from smoke inhalation would have been greatly mitigated. Structural damage would have been comparatively slight.

[16] Transcript 30 September 2014 p.13

322. Although, apparently due to an administrative oversight, no formal document outlining Fire and Rescue's institutional record of lessons learned was ever made final, evidence was given by Assistant Commissioner Brown that the Quakers Hill fire had been very closely analysed by a number of senior officers within the organisation and that various lessons had indeed been learned. Apart from the desirability of sprinkler systems being installed in all nursing homes, these include:

- The automatic fire alarm should have been followed up with a call by a staff member to '000'. This would have led to an immediate escalation in the response by Fire and Rescue;

- Because of the large numbers of people to be rescued from the burning building and the small number of fire fighters who were available immediately in response to the automatic alarm, the Incident Controller had little or no opportunity for some time to step back from the demands of the "fast attack" mode of fire-fighting to a stationary command-and-control mode until more senior officers (and other crews) arrived on the scene. This was less than ideal;

- The urgency of the situation, especially for the first arriving crews, resulted in some standard operating procedures designed for the protection of fire fighters going by the board. For example, it took some time before a tally board identifying the fire fighters and their whereabouts was set up. And it was not until more crews arrived that a Rapid Intervention Team, whose task it is to rescue trapped fire fighters, could be formed;

- Moving non-ambulant patients in their beds was found to be generally more efficient than more labour-intensive methods such as blanket-dragging but congestion in corridors was therefore a significant problem [as it would have been for blanket-dragging];

- It follows from this that exits from wards need to be able accommodate the movement of beds;

- The fire doors in the nursing home worked as designed to contain the fire but also caused jamming of hose lines in the doors and hampering the effort to advance the lines;

- Counting and identification of patients was made unnecessarily difficult during the operation, especially in its early stages, because patient lists were not provided to emergency personnel and patients were not wearing identification tags. As patients were rushed away to hospitals for emergency treatment, this significantly delayed notification of next of kin and hindered distressed families from locating their loved ones;

- It would have been helpful to the arriving crews and, particularly, the Incident Controllers, to have details of the layout and structure of the building, information concerning the fire safety systems and especially the numbers, location and general condition of patients in the building. Ideally, such information ought be available in computerised mobile terminals in Fire and Rescue vehicles.

323. Lessons about the management of drug-affected health professionals have also been learned. As discussed above, although the *Health Practitioner Regulation National Law (NSW) 2009* has instituted a scheme for the mandatory reporting of drug-intoxicated nurses and other health professionals, the 'real world' application of the principles is more difficult than appears on paper. The principle difficulties appear to be (a) interpretation of signs and symptoms and (b) the reluctance of observers to take what may appear to be harsh action against a professional colleague.

324. If this analysis is correct, these problems must be addressed both for the sake of patients and for the drug-affected or drug–dependent health professionals.

325. A further cautionary aspect of the case is obviously that someone with that history could find himself in sole charge of a room full of Schedule 8 medication, and with easy access to a range of prescription medications, is of great concern. There is also a grave suspicion here that Mr Dean may have been substituting weaker analgesics for strong analgesics when medication was administered to residents at the nursing home. This simply cannot be known. However, it illustrates the very real dangers of someone with a prescription medication addiction being employed as a registered nurse in charge of medication at a nursing home.

326. In an article entitled "The impaired nurse: would you know what to do if you suspected drug abused" published by the American Nursing Association, the authors set out a helpful table of signs and symptoms of drug abuse by nurses[17]:

[17] Cynthia M. Thomas, Debra Siela, *Am Nurs Today*. 2011;6(8) http://www.medscape.com/viewarticle/748598 accessed 6 March 2015.

Signs/symptoms	Physical signs	Behavior changes
Brief, unexplained absences from the nursing unit Rounding at odd hours	Shakiness and or tremors Fatigue	Frequent mood changes Outburst of anger Defensiveness
Medication errors	Slurred speech	Inappropriate laughter
Isolation from peers	Frequent use of mouthwash or breath mints	Hyperactivity or hypoactivity
Mood changes after meals or breaks	Watery eyes	Lack of concentration Blackout periods
Frequent reports of lack of pain relief from assigned patients	Constricted/dilated pupils	Justify the addiction to "relax," "need to escape reality
Narcotic or Pyxis obsession, offering to medicate co-workers patients	Diaphoresis	Cold weather clothing in warm weather to hide track marks
Wasted narcotics attributed to a single nurse	Unsteady gait	Frequent accidents or emergencies
Increased narcotic sign-outs	Frequent runny nose	Personal relationship issues
Discrepancies with the narcotic record and or the patient record	Frequent nausea, vomiting and diarrhea	Insomnia Frequent complaints of pain
Altered verbal or telephone medication orders	Weight gain or loss	Denial of problem Frequent lying
Decreased quality of care, documentation arriving late to work and requesting to leave early	Change in grooming	Decreased judgment in their own performance

Source: *Am Nurs Today*. 2011;6(8)

327. It is evident that, at various times, both at the St John of God Hospital and at the Quakers Hill Nursing Home, and possibly also the St George Hospital, Mr Dean displayed a number of these signs and symptoms on a number of occasions. How many occasions is impossible to quantify but I cannot accept the submission put by counsel for Opal that there was virtually nothing except the one incident at St John of God Hospital that might have given warning of Mr Dean's propensities before the fire. Although few of them are individually unambiguous, nurses who had been educated as to the possible significance of a *clustering* of such signs (unexplained absences; incompetence; oddities in medicating patients; mood changes; interpersonal difficulties with other staff or patients; white residue at the corners of the mouth; dishevelled appearance) might have been less hesitant to draw the appropriate conclusions and to take action. Better training in the recognition of the possible significance of the signs is desirable.

328. Secondly, it is human nature to avoid unnecessary conflict, deflect responsibility or, more altruistically, to give people the benefit of the doubt. It is, therefore, important

both to educate health professionals that it is their responsibility to report suspected cases of drug abuse by their colleagues but to make doing so as palatable and as simple as possible. I suggest that this can be done by emphasising, first, the primacy of the interests of vulnerable patients; second, the need to help the affected health professional; and, third, their lack of discretion – reporting is mandatory.

329. These principles apply with even more force to managers.

330. Another conspicuous lesson learned is that it is safer to send an apparently drug-affected staff member or suspected drug thief away from the workplace rather than to take the risk that they will either tamper with or destroy evidence, or cause harm to patients or staff. This is an obvious protection for patients, staff, the affected staff member and the management of a health facility.

331. The fact that Mr Dean was a drug-dependent doctor-shopper who was not identified as either before the fire also highlights the incidental question of doctor-shopping and the urgent need to address it. That issue was comprehensively explored in another inquest in 2014 by my colleague Deputy State Coroner Forbes.[18] It is unnecessary to address the general issues further in detail here beyond noting that it is another important lesson learned.

332. It is, however, important to note that in 2011 Dr Asar knew of the facts that Mr Dean had worked while apparently drug-intoxicated yet took no effective steps to inquire more thoroughly into his real condition. Rather, he appears to have allowed himself to be manipulated by Mr Dean, writing exculpatory letters, prescribing various medications and failing to refer Mr Dean for psychiatric assessment and diagnosis in relation Mr Dean's suggestions that he was suffering bipolar disorder and other serious conditions. He allowed himself to be bluffed into writing a medical certificate to the effect that Mr Dean was 'stable and fit' for duty on very little if any objectively cogent evidence that he was. Mr Dean had been treated with a range of psychiatric medications for about four years without seeking expert psychiatric assessment. Dr Asar's evidence was that Mr Dean refused to see a psychiatrist. That, in itself, might have given him pause before prescribing the range of high-powered medicines he did for Mr Dean. While I do not underestimate the difficulties of GPs trying to manage patients whom they do not recognise to be manipulative drug-seeking people, this was not medicine at its very best.

333. This raises the question whether the mandatory reporting regime concerning nursing and other health professionals needs to be expanded to include cases in which the nurses and others are being treated for mental illnesses or with Schedule 8 medications over a lengthy period. I do not have a definitive answer to the question. Investigating the fits more squarely within the ambit of AHPRA's expertise and jurisdiction than mine. I propose, however, to refer the issue to AHPRA for its consideration.

[18] Inquest into the deaths of Christopher Salib, Nathan Attard and Shamsad Akhtar 27 June 2014 – http://www.coroners.justice.nsw.gov.au/agdbasev7wr/_assets/coroners/m401601l771003/doctor%20shopping%20amended%20finding.pdf

334. Employment practices relating to nursing staff and health professionals generally ought, in my view, always take account of the fact that in nursing homes and hospitals they will have potential access to Schedule 8 drugs. It is also a matter of common knowledge that, because of that access, a proportion of the health workforce has drug dependency issues.[19] A police check is unlikely to show up any drug-related issues for such professionals. They are more usually dealt with by treatment and civil disciplinary methods.

335. It is, therefore, in my opinion, as a matter of best practice, incumbent on employers to check the bona fides of potential health professional employees by conducting reasonably thorough background checks. The *Health Practitioner Regulation National Law (NSW) 2009* lays stress on the public interest in protecting patients and staff in health organisations. Not to conduct adequate background checks on new employees may constitute a serious failing on the part of a health service organisation to protect the public interest. This is a critical lesson to be drawn from this disaster. And, of course, if any further incentive was needed, employers may be exposed to legal liability if they fail unreasonably to check out potential employees .

336. The task for employers would be made easier if the registration details of all nurses and other health professionals included an employment history that could be checked by prospective employers. If Ms Stofan had been able to enquire with AHPRA not only to check whether Mr Dean's registration was current but also the details of his previous employment as a nurse she would have been able to speak to management at the St John of God Hospital. As importantly, Mr Dean would have been unable to conceal his previous employment history from her. This would have reduced his capacity to lie and manipulate the recruitment process. I also propose to refer this issue to AHPRA for its consideration.

337. If AHPRA's system of mandatory reporting and other checks designed to protect patients and staff is or becomes ineffective because it is implemented poorly by practitioners and organisations, more draconian, intrusive and expensive alternatives, such as compulsory drug-testing or giving employers access to employees' health records, may have to be considered. This inquest did not deal with that issue directly, and I emphasise that I do not recommend such a draconian approach, but the issue of drug-dependency and health professionals will not go away. AHPRA has its limits. The onus is on employers and health professionals to make the system work.

[19] See, for example, Jenkins K. 'Keeping the doctor healthy: ongoing challenges'. *MJA* 2009 191:435; Willcock S, Daly M, Tennant C et al. 'Burnout and psychiatric morbidity in new medical graduates'. *MJA* 2004:181:357–360; Elliot L, Tan J, Norris S. 'The Mental Health of Doctors - A systematic literature review.' August 2010. beyondblue. http://www.beyondblue.org.au/index. aspx?link_id=4.1262 ; Cadman M, Bell J. 'Doctors detected self-administering opioids in New South Wales, 1985-1994: characteristics and outcomes.' *MJA* 1998;169:419–421 ; Cicala, R. 'Substance abuse among physicians: What you need to know.' *Hospital Physician* 2003; 39:39–46 (all cited at https://www.avant.org.au/Health-and-Wellbeing/Your-Health/Physical-and-mental-health-and-wellbeing/Substance-abuse-and-the-medical-profession/ accessed 6 March 2015).

338. Identification of patients is a critical issue for all health services. In geriatric services, especially those services caring for patients suffering dementia, identification of patients has added dimensions. On the night of the fire, the confusion and urgency of the evacuation of the building prevented proper identification of patients with armbands. While it was an oversight on my part not to explore that question further, this extreme case probably demonstrates that unless there are good reasons to do otherwise, patients in nursing homes should be wearing armbands at all time. Fires are rare but mistakes in medicating patients are not. They can and do cause serious harm. Armbands are one safeguard against such mistakes. On the night of the fire, armbands identifying patients would have considerably reduced the problems of caring for the survivors of the fire and, indirectly, mitigated the distress of anxious relatives.

339. Whether Schedule 8 drugs ought to have been accessible to Mr Dean or a Registered Nurse on night duty alone is questionable. Again, in fairness to Opal and Ms Stofan, this was not an issue that I explored during the inquest. Nevertheless, I raise the question here because the evidence shows that patients were not frequently seeking PRN ('as required') Schedule 8 analgaesia. On reflection, it seems to me that it is likely that in most cases, Schedule 8 drugs can be administered during morning or afternoon shifts under proper supervision or, alternatively, by means of Webster packs made up in advance.

340. The fire safety auditing of the Quakers Hill Nursing Home was conducted regularly but the fire exposed deficiencies in the auditing process. It did not pick up the fact that the hydrant out the front of the building had insufficient coverage. It did not identify the problems with ramp at the rear exit. It did not identify that the ramp was probably an unauthorised extension or addition to the building. It did not identify that the fire compartments may have been compromised by battens penetrating the fire walls dividing the compartments.

341. As I have discussed earlier, the fire safety auditing process appears to have been conducted with a view to meeting certain requirements for paperwork to be filed rather to have been conducted with real fires and real lives in mind at the centre of the investigation. Checklists are aides memoire not ends in themselves. That, of course, is a cultural issue rather than a regulatory issue. I have no magical solution to our human tendency to take the path of least resistance (eg, ticking boxes). It is, however, something that the experts in Fire and Rescue NSW may wish to consider.

Should more be done? Recommendations

342. In addition to supporting the recommendations made by Deputy State Coroner Forbes in her inquest concerning doctor-shopping, I propose to make a number of recommendations based on the lessons that I believe should be drawn from this disaster:

- That the NSW government provide funding for the instalment of mobile data terminals in Fire and Rescue NSW vehicles;

- That Fire and Rescue NSW develop a digital data base of pre-incident plans for use in major structural fires;

- That Fire and Rescue NSW develop and disseminate a 'lessons learned' e-learning package to all staff with particular emphasis on issues that arose in relation to the Quakers Hill Nursing Home fire. Topics of high significance would include urgent escalation of the alarm level for structure fires involving building occupied by large numbers of people; rescue techniques, especially the rescue of non-ambulant patients and patients attached to medical equipment; and management of hose lines jammed in fire doors;

- That Fire and Rescue NSW and the Department of Planning work together to address the issue of hose lines becoming jammed in fire doors;

- That, pending the results of any such consultation, Fire and Rescue NSW consider either issuing fire fighters with blocks or wedges to enable them to advance lines without undue hindrance or, alternatively, that, if resources and circumstances allow, whenever a hose line is being advanced, a fire fighter be tasked to keep advancing lines free until he or she is no longer required for that purpose;

- That Fire and Rescue NSW consider issuing a bulletin to all aged care and other types of residential facilities in NSW identifying the difficulties encountered by fire fighters at the Quakers Hill Nursing Home fire and the lessons learned. In particular, emphasis might be laid on:

    a. The urgent necessity for at least one '000' (and preferably more than one) call to be made by staff following a fire alarm to give FRNSW time to 'scramble' appropriate resources to attend the fire;

    b. That staff cross-check with one another to ensure that a '000' call has been made and to make one if unsure;

    c. That staff members remove patients or residents then close ward doors and other fire doors as quickly as possible to confine fires within fire compartments;

    d. That removal of non-ambulant patients and residents should, if reasonably practicable, be done by wheeling them out of danger in beds or wheel-chairs but that alternative dragging methods may need to be employed;

    e. That if patients are wheeled out of their wards or rooms efficiently, passage ways must be kept as clear as is reasonably practicable;

f. That the facility's fire evacuation plan takes into account potential impediments to rescuing non-ambulant patients, such as connection to medical equipment, and makes specific provision for addressing those challenges in an emergency;

g. That fire exits and other doors be kept clear of obstructions that could hinder urgent movement of non-ambulant patients in the case of sudden emergency;

h. That facilities include in their fire and emergency training regular scenario-based practical training including practice of the urgent removal of non-ambulant patients and residents.

- That nurses and other health professionals working in environments in which Schedule 8 drugs are dispensed to patients be educated to recognise the signs of possible drug-dependency in their professional colleagues. The table of signs and symptoms developed by the American Nurses' Association (see above at [325]) may provide a useful foundation for such education;

- That AHPRA consider requiring employers to notify it when a health professional falling under the agency's jurisdiction commences work and when he or she leaves that employment;

- That AHPRA consider including employment details in its registration data base. Those details might include name and contact details of the employer; period of employment; and any notifications made to AHPRA concerning the employee;

- That consideration be given to amending the *Poisons and Therapeutic Goods Regulation* to increase security of Schedule 8 drugs in nursing homes and similar facilities;

- That the Commonwealth Department of Social Services and the NSW Department of Aged Care, Disability and Home Care, in consultation with peak industry bodies such Aged and Community Services Australia Inc, consider publishing in their media outlets a 'lessons learned' case study document dealing, in particular, with the issues of signs of drug-dependency among nursing staff and other health professionals; mandatory reporting requirements; scrutiny of employment records in which large gaps appear; security of Schedule 8 drugs; and emergency evacuation training.

In conclusion

343. It is difficult to imagine the terror and horror that the victims of this dreadful atrocity must have felt as they lay trapped choking on dark smoke with a fire blazing nearby. Family members have spoken for many of them. All were good decent people who had lived for others and who deserved so much better than this in the last stages of their

lives. At least it can be said that they are now at peace. They remain dear and much-loved by their families and friends. Perhaps those of us who participated in this inquest but who did not know them can gain some insight into the sorts of people they were from dignity and compassion their families and friends brought to the courtroom.

344. I hope, and I am sure that all those who have been involved in the case hope, that this tragedy will result in lessons being learned and implemented that will save other vulnerable people from harm and death in future years.

Findings: Sections 81 and 30 Coroners Act 2009

345. I find that Alma Smith died on 18 November 2011 at Quakers Hill Nursing Home, Quakers Hill, New South Wales due to smoke inhalation she suffered as a person with severe ischaemic heart disease and emphysema during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean.

346. I find that Dorothy Wu died on 18 November 2011 at Quakers Hill Nursing Home, Quakers Hill, New South Wales due to smoke inhalation and burns she suffered during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean.

347. I find that Dorothy Sterling died on 18 November 2011 at Quakers Hill Nursing Home, Quakers Hill, New South Wales due to smoke inhalation and burns she suffered during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean.

348. I find that Lola Joyce Bennett died on 18 November 2011 at Royal North Shore Hospital, St Leonards New South Wales due to smoke inhalation and burns she suffered during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean.

349. I find that Ella Wood died on 19 November 2011 at the Concord Hospital, New South Wales due to smoke inhalation and burns she suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean.

350. I find that Urbana Alipio died on 20 November 2011 at the Liverpool Hospital, New South Wales due to the effects of smoke inhalation she suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean.

351. I find that Caesar Galea died on 21 November 2011 at the Hawkesbury Private Hospital, Windsor New South Wales due to the combined effects of acute exacerbation of chronic airways limitation precipitated by smoke inhalation he suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean, and the effects of sigmoid colonic infarction.

352. I find that Doris Mercy Becke died on 21 November 2011 at the Blacktown Hospital, New South Wales due to the effects of smoke inhalation she suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean.

353. I find that Reginald Joseph Green died on 25 November 2011 at Westmead Hospital, New South Wales due to the effects of smoke inhalation he suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean.

354. I find that Verna Noeleen Webeck died on 29 November 2011 at the Royal North Shore Hospital at the Liverpool Hospital, New South Wales due to the effects of burns and smoke inhalation she suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean.

355. I find that Neeltje Valkay died on 22 November 2011 at the Liverpool Hospital, New South Wales due to the combined effects of smoke inhalation she suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean and a cervical spine fracture she incurred by falling out of bed in hospital following her admission after the fire.

356. I find that Esther Newham died on 19 December 2011 at the Adventist Nursing Home, Kings Langley, New South Wales due to 'extreme old age' or natural causes although she had been exposed to some smoke on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean.

357. I find that Joan Joy died on 4 December 2011 at Garden View Aged Care facility, Paton St, Merrylands, New South Wales due to a combination of age and natural causes including kidney disease, heart disease, chronic lung disease and gastrointestinal disease although the stress of being disconnected from her dialysis machine and of being removed from the nursing on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean may have been a contributory factor in her death.

358. I find that Emmanuela Cachia died on 9 March 2012 at Westmead Hospital, New South Wales due to multi organ failure probably due to sepsis resulting from a hospital-acquired infection following her admission for the effects of smoke inhalation she had suffered on 18 November 2011 during a fire deliberately lit in the A1 wing of the nursing home by Roger Dean.

359. In relation to the fire inquiry pursuant to s30 of the Coroners Act, I find that the fire at the Quakers Hill Nursing Home on 18 November 2011 was caused Roger Dean deliberately lighting fires in beds in ward 19 of the A2 wing and ward 3 of the A1 wing.

Recommendations: s 82 Coroners Act

360. I make the following recommendations to the Minister for Emergency Services and the Commissioner for Fire and Rescue NSW:

- That the NSW government provide funding for the instalment of mobile data terminals in Fire and Rescue NSW vehicles;

- That Fire and Rescue NSW develop a digital data base of pre-incident plans for use in major structural fires;

- That Fire and Rescue NSW develop and disseminate a 'lessons learned' e-learning package to all staff with particular emphasis on issues that arose in relation to the Quakers Hill Nursing Home fire. Topics of high significance would include urgent escalation of the alarm level for structure fires involving building occupied by large numbers of people; rescue techniques, especially the rescue of non-ambulant patients and patients attached to medical equipment; and management of hose lines jammed in fire doors.

- That Fire and Rescue NSW and the Department of Planning work together to address the issue of hose lines becoming jammed in fire doors;

- That, pending the results of any such consultation, Fire and Rescue NSW consider either issuing fire fighters with blocks or wedges to enable them to advance lines without undue hindrance or, alternatively, that, if resources and circumstances allow, whenever a hose line is being advanced, a fire fighter be tasked to keep advancing lines free until he or she is no longer required for that purpose;

- That Fire and Rescue NSW consider issuing a bulletin to all aged care and other types of residential facilities in NSW identifying the difficulties encountered by fire fighters at the Quakers Hill Nursing Home fire and the lessons learned. In particular, emphasis might be laid on:

- The urgent necessity for at least one '000' (and preferably more than one) call to be made by staff following a fire alarm to give FRNSW time to 'scramble' appropriate resources to attend the fire;

- That staff cross-check with one another to ensure that a '000' call has been made and to make one if unsure;

- That staff member remove patients or residents then close ward doors and other fire doors as quickly as possible to confine fires within fire compartments;

- That removal of non-ambulant patients and residents should, if reasonably practicable, be done by wheeling them out of danger in beds or wheel-chairs but that alternative dragging methods may need to be employed;

- That if patients are wheeled out of their wards or rooms efficiently, passage ways must be kept as clear as is reasonably practicable;

- That the facility's fire evacuation plan takes into account potential impediments to rescuing non-ambulant patients, such as connection to medical equipment, and makes specific provision for addressing those challenges in an emergency;

- That fire exits and other doors be kept clear of obstructions that could hinder urgent movement of non-ambulant patients in the case of sudden emergency;

- That facilities include in their fire and emergency training regular scenario-based practical training including practice of the urgent removal of non-ambulant patients and residents.

361. I make the following recommendation to the NSW Ministers for Emergency Services and Planning and the Commissioner for NSW Fire and Rescue NSW:

- That Fire and Rescue NSW consult as to the best and most practical means for ensuring that in a structural Fire and Rescue's hose lines can be advanced beyond fire doors without either jeopardising the integrity of fire compartments or jamming hose lines.

362. I make the following recommendations to the Commonwealth and New South Wales Ministers for Health and the Chief Executive Officer of the Australian Health Practitioner Regulation Agency:

- That AHPRA consider requiring employers to notify it when a health professional falling under the agency's jurisdiction commences work and when he or she leaves that employment. I recommend that any regulatory changes necessary to implement such a practice be given urgent consideration;

- That AHPRA consider including employment details in its registration data base. Those details might include name and contact details of the employer; period of employment; and any notifications made to AHPRA concerning the employee. I recommend that any regulatory changes necessary to implement such a practice be given urgent consideration

363. I make the following recommendation to the NSW Minister for Health:

- That she refer this case to the Poisons Advisory Committee to consider whether regulations under the Poisons and Therapeutic Goods Regulation 2008 should be amended to improve security of Schedule 8 drugs in nursing homes and similar facilities;

- That she consider requiring nursing homes by regulation to use identification armbands on all patients at all times unless there are overriding medical reasons not to do so.

364. I make the following recommendation to the Commonwealth Minister Social Services and the NSW Minister for Ageing:

- That the Commonwealth Department of Social Services and the NSW Department of Aged Care, Disability and Home Care, in consultation with peak industry bodies such Aged and Community Services Australia Inc, consider publishing in their media outlets directed towards services providing residential care a 'lessons learned' case study document dealing, in particular, with the issues of signs of drug-dependency among nursing staff and other health professionals; mandatory reporting requirements; scrutiny of employment records in which large gaps appear; security of Schedule 8 drugs; and emergency evacuation training.

Magistrate Hugh Dillon
Deputy State Coroner for NSW