QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the Palace Backpackers Hostel Fire**
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Childers
FILE NO(s):	BRIS-COR 404-418/00
DELIVERED ON:	7 July 2006
DELIVERED AT:	Childers
HEARING DATE(s):	26 June 2000, 22 January 2001, 25 February 2006, 3-5 July 2006
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	**CORONERS: Inquest, arson in budget accommodation, fire safety reforms.**

REPRESENTATION:

Counsel Assisting:	Mr Alan MacSporran, SC
Families of the Next of Kin:	Mr Mitchell Brown (Slater & Gordon)
Department of Emergency Services & Department of Planning and Local Government:	Mr Martin Burns (instructed by Crown Law)
Isis Shire Council:	Mr Damien Atkinson I(instructed by Barry Nillson Lawyers)
Where on Earth Pty Ltd, Mr Christian Atkinson & Mr John Dobe:	Mr A Rafter SC (instructed by McCullough Robertson Lawyers)
Jarrett Electrical:	Mr Ralph Devlin SC (instructed by Clayton Utz Lawyers)
Ms Patricia Wood:	Mr Ron Ashton (instructed by Carew Lawyers)

Findings of the Inquest into the Palace Backpackers Hostel Fire

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1. Introduction

The fire that burnt down the Palace Backpackers Hostel on 23 June 2000 killed fifteen people and left a scar on the lives of their families and friends. It traumatised the community of Childers and shocked the whole state. People all over the country, indeed all over the world, who saw the photographs of the charred remains of parts of the hostel, could imagine the horror of that night and the intensity of the grief that followed. It was a savage reminder of the danger of fire and a warning that unless proper precautions are taken, crowded accommodation facilities can be extremely dangerous.

The man who lit the fire has been sentenced to life imprisonment but the question remains whether anyone else should be charged with criminal offences for his or her involvement in the fire. The circumstances of the disaster call for inquiry as to whether public authorities with responsibilities to regulate commercial accommodation facilities adequately discharged them. Further, those who lost loved ones and the public are entitled to an explanation of why the loss of life was so great. It is also essential that those most directly affected and the public can be assured that changes made to the monitoring of safety in such facilities will effectively remove the likelihood of similar tragedies occurring in the future.

This inquest examined the events surrounding the fire from a number of very different perspectives. A criminal prosecution is a mechanism to punish wrong doing and to demonstrate society's repugnance for acts that cause death if the courts deem those responsible sufficiently culpable. One of the functions of these proceedings has been to consider whether anyone should be committed for trial. Perhaps contrary to intuition, the survivors of violent incidents and those bereaved by the sudden deaths that result, commonly want to know as much as possible about what happened. The paternalistic idea that it's better to shield those so affected from this information has been repeatedly shown by research to be ill-conceived. In seeking to satiate those needs, this inquest is part of what is now referred to as therapeutic jurisprudence. Consistently, the survivors of disasters articulate a fervent desire that no one else suffer as they have. The public are also entitled to be assured that any failings that contributed to these deaths have been addressed.

The resolution of all of these issues is the goal of this inquest.

The Coroners Act 1958 provides in s43(1) that after considering all of the evidence given before a coroner at an inquest the coroner shall give his or her findings in open court. What follows are my findings in the inquest held into the deaths caused by the fire in the Palace Backpackers Hostel.

2. The Coroner's jurisdiction

In England, coroners have investigated sudden and violent deaths for eight hundred years and they have done the same in this country since European occupation. However, many people still have a limited understanding of the role and function of coroners and inquests. A potential for further confusion arises in this case as a result of the passing of the *Coroners Act 2003* in the period intervening since the deaths investigated by this inquest. It is therefore appropriate that before I turn to an examination of the evidence in this case, I say something about those issues, to put what comes after in some context.

2.1 The basis of the jurisdiction

Although this inquest was concluded in 2006, as the deaths and the fire being investigated occurred before 1 December 2003, the date on which the *Coroners Act 2003* was proclaimed, it is a "*pre-commencement death*" within the terms of s100 of that Act and the provisions of the *Coroners Act 1958* (the Act) are therefore preserved in relation to it.

Because the deaths occurred in circumstances of suspicion and were violent and unnatural, the police who attended the scene were obliged by s12(1) of the Act to report them to a coroner. Section 7(1)(a) (i) and (iii) confer jurisdiction on a coroner to investigate such deaths and s7B authorises the holding of an inquest into them. If any authority is needed to look beyond the immediate cause of the deaths and to inquire into the cause of the fire, that can be found in s8 which authorises a coroner to inquire into the cause and origin of a fire when property is destroyed and/or life endangered or lost.

2.2 The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death.

The Act, in s24, provides that where an inquest is held, it shall be for the purpose of establishing as far as practicable:-

- the fact that a person has died,
- the identity of the deceased,
- when, where and how the death occurred, and
- whether anyone should be charged with a criminal offence alleging he/she caused the death.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proven.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends…*

> *The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations,[2] referred to as "*riders*" but prohibits findings or riders being framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence.[3]

2.3 The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s34 of the Act provides that "*the coroner may admit any evidence the coroner thinks fit"* provided the coroner considers it necessary to establish any of the matters within the scope of the inquest.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt; an inquiry rather than a trial.[4]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

Of course, when determining whether anyone should be committed for trial, a coroner can only have regard to evidence that could be admitted in a criminal trial and will only commit if he/she considers an offence could be proven to the criminal standard of beyond reasonable doubt.

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[7] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[8] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s43(5)
[3] s43(6)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[8] (1990) 65 ALJR 167 at 168

3. The investigation

I turn now to a description of the various investigations that followed the fire. They can broadly be divided into the investigation of the criminal offences and the technical aspects of the cause and course of the fire.

3.1 The Queensland Police Service (QPS) criminal investigations

Police established a crime scene on the morning of 23 June 2000. Warrants under the provisions of the *Police Powers and Responsibilities Act 2000* and the *Coroners Act 1958* were issued.

A major incident room was established in Childers and the Homicide Investigation Group, Arson Investigation Unit and Bundaberg Criminal Investigation Bureau (CIB) conducted investigations.

All backpackers who survived the fire were interviewed as were a number of passersby.

Assistance was obtained from specialist sections within the QPS and other government agencies and external specialists.

An interactive crime scene was filmed and large quantities of photographs were taken of the various rooms within the building. A sketch plan of the scene was also created using a theodolite.

A number of fire scene investigators conducted examinations of the fire scene. These included:

- Sergeant R. Graham — Police Scientific Section
- Terry Casey — Forensic Services Australia
- Greg Reynolds — Qld Fire and Rescue Authority
- Alan Faulks — Electrical Safety Inspector

The *area* of origin of the fire was determined by all forensic examiners to be the television lounge room in the lower level, south eastern corner. The *point* of origin of the fire and cause of the fire was unable to be determined due to the extent of damage within this room.

The QPS Scientific Section and Forensic Services Australia took possession of samples of debris from a number of locations within the *area* of origin. These samples were tested for the presence of flammable liquids and all results were negative.

The QPS and the Queensland Fire and Rescue Authority (QFRA) commissioned various private forensic examinations to provide some technical support to the fire scene examination. All of the investigation information was provided to Gilmore Engineers Pty Ltd to create a modelling of the fire and its propagation.

I am satisfied that the investigation conducted by the QPS was thorough, sufficient and competently carried out. I commend the officers involved for their work. Detective Sergeant Campbell in particular is to be commended for his dedication to a long and difficult job.

3.2 The technical investigations

A number of technical investigations and examinations were undertaken. A description of those is set out below. Their results are summarised in section 5.9.

3.2.1 QFRA Fire Incident Report

This report assessed the management of the incident and canvassed a number of the fundamental areas including the response by emergency services, the scene confronting firefighters when they arrived and the actions taken by QFRA.

3.2.2 QFRA Fire Investigation Report

This report examined the cause and origin of the fire and also identified contributing factors such as the disabled fire alarm, the malfunctioning illuminated exit signs and the security bars on some windows.

3.2.3 QFRA Building Fire Safety Report

This report analysed legislation current at the time, effecting fire safety as well as making specific findings in regard to means of escape, means of maintaining the means of escape, fire protection equipment, means for fighting fire, fire compartmentation and occupant safety.

3.2.4 Electrical Safety Office Report

This report examined the electrical installation of the complex commencing with the likely room of origin, the television lounge room. To aid the investigation, the room was divided into nine segments. An examination of the installation of the fire alarm system was also carried out. The control panels, three alarms and two thermal alarms were removed for further examination by the Queensland University of Technology School of Electrical & Electronic Systems Engineering.

4. The inquest

4.1 Introduction

On 26 June 2000, Brisbane Coroner Michael Halliday opened an inquest into the deaths of the 15 people who died as a result of the fire. The matter was then adjourned to await the completion of the police investigation report.

Robert Paul Long was subsequently arrested and charged with two counts of murder and one count of arson. Section 42(1) of the *Coroners Act 1958* required that the inquest be adjourned until the charges had been disposed of.

Following Mr Long's committal for trial on all charges, Mr Halliday convened a mention of the matter in Brisbane on 22 January 2001. After submissions from the Office of the Director of Public Prosecutions (DPP) and the defence, Mr Halliday adjourned the inquest to a date to be fixed following the conclusion of all Supreme Court proceedings on the basis that inflammatory material could have found its way into the public domain and possibly prejudiced or compromised a fair and impartial trial.

Mr Long was convicted of the murders of the sisters Kelly and Stacey Slarke and the arson of the hostel on 15 March 2002. He was sentenced on 18 March by His Honour Justice Dutney to life imprisonment for the murders and to 15 years imprisonment for the arson.

An appeal to the Court of Appeal was dismissed on 28 February 2003. An application for special leave to appeal to the High Court of Australia was refused on 23 June 2004.

The *Coroners Act 1958* requires findings to be made in relation to each death. As criminal proceedings had been finalised and Mr Long had exhausted all avenues of appeal, the inquest could be resumed so that formal findings could be made and riders relating to preventative issues could be considered.

4.2 Directions Hearing

On 24 February 2006 I resumed the inquest with a directions hearing. It was convened in Brisbane for the purposes of establishing the scope, issues and witnesses to be examined at the inquest.

Mr Alan MacSporran SC was appointed to assist me. The State of Queensland, through its instrumentalities, the Department of Emergency Services and the Department of Local Government, Planning, Sport and Recreation, were granted leave to appear. Leave was also granted to the Isis Shire Council, the owner and operators of the hostel, the families of the deceased and the electrician responsible for the repair of the alarm system.

Counsel Assisting read into the record the issues to be examined at the inquest and the proposed witnesses.

Mr Robert Long, through his legal advisers, was notified of the directions hearings. Mr Chowdhury appeared for Mr Long. However, after Counsel assisting read the issues into the record, Mr Chowdhury advised the court that he did not seek leave to appear at the inquest.

An invitation was extended to Mr Long, through his legal advisers, to give evidence at the inquest. Mr Long declined this invitation.

Counsel Assisting informed the court that multiple civil actions had arisen as a result of the fire and its consequences. Those actions were listed for mediation in March and if necessary for trial in May 2006. The District Court had set aside a block of dates in May for the trial to proceed until finalisation.

Counsel Assisting submitted that bearing in mind the issues which would be canvassed in the civil action, those issues would significantly overlap with issues to be canvassed at the inquest. Accordingly, it would be appropriate to postpone the inquest until after the civil actions had been determined.

It was determined that the appropriate venue for the proceedings would be Childers. I then adjourned the matter to Childers to commence on 3 July 2006.

The court was notified in mid-June that the survivor claims had settled but actions by the next of kin were continuing. Given the delay that had already occurred, I determined it was appropriate to proceed to finalise the inquest.

4.3 The Inquest

The inquest commenced on 3 July 2006 and evidence was given on that day and the next two days. Twenty witnesses were called to give oral evidence and 440 exhibits were tendered.

The operators of the hostel exercised their right not to answer questions on the basis that they might incriminate themselves.

At the conclusion of the evidence I received submissions from Counsel assisting and the barrister representing the hostel operators, Mr Rafter SC, concerning the committal question. Counsel Assisting submitted that the only two people concerned with this question were the two operators of the hostel at the time, Mr Atkinson and Mr Dobe. In his opinion there was insufficient evidence to commit either of the operators for trial. Mr Rafter SC supported Mr MacSporran's submissions as did the legal representatives of those families who had sought leave to appear.

I then heard from Mr Burns for the State of Queensland and Mr Atkinson for the Isis Shire Council in connection with possible findings adverse to their respective clients.

5. The Evidence

I turn now to the evidence. I cannot, of course, even summarise all of the information contained in the exhibits and transcripts but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

5.1 History of the building until 1993

The building was a two storey commercial structure erected in about 1902. It was constructed to replace an earlier two storey timber hotel that was ironically also destroyed by fire.

The hotel was originally constructed of double brick. Some time around 1932, a second two storey accommodation wing was built behind the first. The two blocks remained unattached until the 1950's to 60's when a skillion roof was constructed covering the space between the two buildings. This construction formed an area that commonly became known as the atrium with a timber walkway joining the upper storeys of both blocks.

At the time of the fire the hostel had three distinct areas which for ease of description has been split into the following sections:

Block A – Northern block facing onto Churchill Street;
Block B – Central adjoining block; and
Block C – Rear ablutions block (completed in 1995).

The building comprised brick load bearing walls with cement rendering applied to the external and internal lining. The internal floors and non-load bearing walls were timber, with plaster and fibro blend ceiling linings. An iron clip lock roof over the atrium joined blocks A and B.

Block A was closest to Churchill Street and had two levels. The first floor comprised bedroom accommodation and a manager's kitchen. The ground floor consisted of an office and a 25 bed dormitory.

Block B was located directly behind and parallel to block A. They were joined by a two storey roofed atrium. Block B also had two levels. The first floor consisted of bedroom accommodation and the ground floor was divided into a tv/dining room and kitchen area.

Block C was a single level building housing the ablutions and electronic amusement machines.

The hostel was constructed of the following materials:

BLOCK	TYPE	MATERIAL
Block A	**Walls**	External – cavity brick Internal – a combination of brick and plaster, lightweight timber framing and fibro, and VJ timber
	Ceiling Lining	Ground floor – pressed metal First floor – VJ Timber
	Roof Lining	Timber purlins and iron roof
	Floor lining	Ground floor – concrete First floor – Dorm 7 (ex bathroom) had concrete floor, all other areas had timber floor
Block B	**Walls**	External – cavity brick Internal – combination of brick and plaster, lightweight timber framing and fibro, and VJ timber

	Ceiling Lining	Ground floor – fibro in television/Dining Room Ground floor – VJ and plasterboard in the communal kitchen First floor – fibro
	Roof Lining	Lightweight metal purlins with zinc sheeting
	Floor lining	Ground floor – concrete First floor – timber floor joists and floor boarding
Block C	**Walls**	Concrete block construction
	Ceiling Lining	Fibro
	Roof Lining	Female ablutions – reinforced concrete deck Male ablutions
	Floor lining	Ground floor – concrete Deck Area – concrete

From 1902 until about 1987 the premises operated as a hotel. The building was then purchased by Roy Salt who operated an antique shop in the premises until 1991 when he sold the building to Patricia Woods. Ms Woods then resided in the building until 1993 when she met Peter Moore. Mr Moore informed her that he wished to turn the hotel into a backpacker's hostel. She subsequently leased the building to Mr Moore and moved to other premises within the town. There is no suggestion that any structural changes were made to the building prior to 1993 however the bar was removed at some point between 1987 and 1993.

5.2 History of the backpackers hostel

Surfie Pty Ltd

In April 1993 Mr Moore approached Mr John Hartnett, the Assistant Building Surveyor at the Isis Shire Council, for advice concerning the conversion of the building into a backpackers hostel. He wanted to know what he would need to do to obtain council approval. He recalls taking Mr Hartnett to the building and showing him through, indicating the changes he intended to make. He had at that time been running a backpackers hostel in Bundaberg for 3 or 4 years and was seeking to establish a similar business in Childers.

Following Mr Moore's approach, Mr Hartnett agreed to make some inquiries and then provide him with his opinion. Mr Hartnett reviewed the building code and council by-laws relating to the building. He subsequently advised Mr Moore that an application to alter the classification of the building was unnecessary as the building was already a Class 3 (Part A3.2 of the Building Code: a boarding house, guest house, hostel, lodging house or backpackers

accommodation) based on its original use as an hotel at the time of construction. Mr Hartnett stated in evidence that this was his decision only and it wasn't a matter that required council consideration.

It was agreed that Mr Lawgall, the Fire Safety Officer for the region should be consulted about fire safety equipment and he attended at the site and recommended that a fire alarm of the same kind that had been installed in Mr Moore's hostel should be installed in the Palace. Mr Moore agreed to do this.

Mr Hartnett did advise Mr Moore however that he would have to formalise his intentions, which he did by letter dated 26 May 1993. In his letter he applied to Council for consent to use the hotel as a backpackers hostel. Mr Hartnett gave evidence that he noted on the reverse of that letter 18 items he considered would need to be addressed before this could happen. Although the evidence is unclear this probably reflects Mr Hartnett noting on the back of this letter the terms of a conversation he had earlier, namely 20 March 1993.

Relevantly for our purposes those items included exit signs and emergency lighting, testing of fire hose reels, installation of fire extinguishers, fire rating of doors, and the installation of sprinklers or a fire alarm system. The effect of the evidence was that there was no requirement under the then current legislation to install and maintain a fire alarm system. Mr Moore gave evidence that he took on board the suggestions and to the best of his recollection complied with each of the items before opening for business in September 1993.

Mr Hartnett stated that the items he had recommended weren't binding as the building was constructed prior to 1975 and fire safety systems were only applicable to buildings erected after 1975. Mr Hartnett stated that he was only authorised to make requirements under the building code and it was a matter for the applicant as to whether they in fact attended to the suggested works. Fire safety alarms were not equipment that could be insisted on.

The work undertaken by Mr Moore included refurbishing the downstairs office, the installation of grates on the windows in the office for security and plumbing for the ablutions block. Mr Moore stated that the activities room downstairs was never a recreation room as it is shown on the only floor plan submitted to council and was always intended to be a large dormitory. He said it was necessary however to seal off some of the doors because they opened directly onto Churchill Street. He also recalls that the bars on the bathroom window upstairs were there when he took over the lease.

Mr Moore stated in evidence that Mr Hartnett would call in at the hostel at least three times a week to check on the progress of the conversion and all work was done as required by the Council.

Mr Hartnett conducted an inspection of the hostel and completed a Certificate of Classification dated 21 September 1993. The certificate authorised the use of the building as a hostel provided a number of matters identified in the certificate were attended to. These were listed on the Certificate and signed

off by the then CEO of the Council on 27 September 1993. The following items were identified for rectification:

- Lever type handle to back doors;
- Back door to first level to swing in direction of egress;
- Test certificate for hose reels;
- Provision of sign alongside back fire hydrant;
- General clean up;
- Completion of second ablution area;
- Inspection of installation of internal security gates inside front door; and
- Provide engineers certificate for suspended slab.

In relation to the ablutions block noted above the certificate indicated that Council were to be notified following completion so that an inspection could be performed.

A final inspection of the hostel was never made as the owners did not invite Council back. No application for extension of building approval exists on file. In his evidence, Mr Hartnett said the Council had had no powers of entry without the consent of the owner otherwise it was necessary to obtain a warrant from a magistrate. There seems little doubt that had it wanted to, the council could have checked that the work it stipulated had been done.

During the conversion process, Mr Moore also met with the health inspector from the Council. He recalls that the health inspector spent about three-quarters of a day calculating the volume measurement of the bedrooms in order to establish the allowable occupancy of the hostel, which he remembers as being a maximum of 90 people. There is no record of this anywhere.

Mr Hartnett confirmed in his evidence that occupancy levels were not a matter for his consideration but rather the health inspectors. He was aware of limitations placed on occupancy by virtue of local laws which he thought was calculated by cubic metre per room. He presumed the occupancy levels were around the 80/90 mark.

While it is not clear how this number was actually calculated the evidence from Mr Hartnett was that the policy implementing the council local law which operated from 8 June 1999 would have set as a maximum number of occupants for this hostel at 53. There is no evidence that the Council sought to enforce this limit at the Palace Backpackers Hostel.

The alarm system was purchased from Berajondo Fire Protection Services and had both thermal and smoke detectors. Mr Lionel Terry from Berajondo submitted to the Isis Shire Council plans of the system in addition to the datasheets and specifications. The plans were stamped as being part of the application for consent to use the building as a hostel. This may have been to certify the existence of the hose reels and lights that were required as a part of the application. These plans show that in the upstairs block A, room 7 was shown to be a bathroom and the downstairs A block dormitory to be an “Activities Room.”

Mr Terry was not an electrician and Mr Moore wanted the system hard wired into the mains power supply. It was therefore necessary to arrange for someone else to install the system which Mr Moore did. Mr Mark Chesson did the job.

Mr Moore's recollection is that he never had any difficulty with the alarm system and it wasn't necessary for him to have it tested or checked as his guests did that for him when they set if off by smoking in the building.

Mr Moore gave evidence that all fire safety installations were in operating order when the business was sold in July 1994.

Viewleigh Pty Ltd

In July 1994 the lease of the hostel was sold to Viewleigh Pty Ltd, a company owned and operated by John and Sue Gardner. Mr Gardner gave evidence that at the time he took possession of the premises it was operating as a 90 bed hostel.

Mr Gardner stated in his evidence that he sought the advice of Mr Hartnett in mid-1995 concerning some modifications he wished to make to the hostel. These included converting the upstairs bathroom, which was at that time a vacant storeroom, into a dormitory and extensions to the rear of the building to construct a toilet block. The modifications to the upstairs bathroom did not involve any structural change, simply the removal of plumbing. Both agree that Mr Hartnett gave verbal approval for these changes. The Council file does not record Mr Hartnett's approval to modify the room.

Mr Gardner's recollection was that he did not inform Council how many people would be accommodated in the room because the intention was not to increase the number of occupants in total. Rather, according to him it simply involved relocating some of the existing beds into that room.

Mr Hartnett's evidence on that point was that Mr Gardner informed him there would be ten people accommodated in that room but that it would not increase the total occupancy of the hostel as he would simply relocate some of the other beds to that room.

In relation to this issue it is noteworthy that the evidence at the inquest indicates that the hostel was permitted by the Council to operate with up to a maximum of 90 persons in residence. Local Law No. 12 which apparently came into operation in 1996, dealt with the Council's requirements for rental accommodation. It provided no guidance as to how occupancy levels were to be calculated. The Local Law Policy which provided the guidelines did not come into force until 8 June 1999. If this policy had been applied at 23 June 2000, only 53 persons would have been permitted in the hostel. There was never any action taken by the Council to enforce such a limitation on occupancy numbers at the hostel.

Room 7 had two sets of doors plus a sash window with security bars. Mr Gardner completed the conversion of that room into a dormitory and installed two double bunks perpendicular to the wall adjacent to the atrium verandah and placed two triple bunks along the opposite wall. The placement of these bunks obstructed a set of doors. Mr Gardner had considered doing away with the doors altogether but in the end he elected just to secure the doors with screws. The blocked doorway opened onto a corridor that gave access to the front verandah of the building. Mr Gardner did not seek the advice of fire safety officers when he did this.

When Mr Gardner purchased the lease he contracted with Berajondo to test and maintain the fire appliances, such as the fire hoses and extinguishers, every three or six months. Records of these inspections were maintained by Berajondo.

The maintenance contract did not extend to the alarm system however.

Mr Gardner gave evidence that in about 1997 he started to have persistent problems with the alarm system. He contacted a local electrician, Mr Geoff Jarrett, who agreed to inspect the alarm system.

Mr Gardner reported that the alarm had been false alarming and arcing out and would sometimes emit noises. Mr Jarrett couldn't identify the source of the problem so advised Mr Gardner that the system would need to be sent to Tyco Services in Brisbane for repair. Mr Gardner's recollection was that of the two units, the one which indicated the zones was sent away and not the unit with the key. He recalls the panel being away for weeks rather than days.

Mr Gardner informed the court that he has always been concerned about fire safety after having spent some time in the Navy so he had Mr Jarrett install a number of stand-alone smoke detectors to provide some protection while the alarm was being repaired.

Mr Jarrett confirmed that he first did work on the alarm system in 1997 after Mr Gardner contacted him regarding a malfunctioning of the system. He reported that when the key was switched to the 'on' position the alarm would sound without smoke being present. Mr Jarrett was unable to identify the source of the problem so sent it to Tyco Services for repair. Mr Jarrett gave evidence that he sent both units, W52 and W54 to the manufacturer.

Mr Jarrett couldn't remember how long the repairs took but he thinks it was in the order of four weeks. When the system was returned he re-installed it at the hostel and took down the stand-alone battery operated smoke detectors.

It doesn't appear that Mr Gardner had any further difficulty with the alarm prior to him selling the lease to Where on Earth Pty Ltd in 1999.

At the time of the sale Mr Gardner was informed that a Fire Inspection Certificate was necessary and he was asked by the solicitors acting for Where on Earth if he had a current certificate. Mr Gardner wasn't aware that one

was required. Negotiations then commenced with the solicitors as to who should pay for the inspection.

A quote was prepared by Mr Terry Newman of the QFRA and sent to the solicitors on 20 January 1999.

Mr Newman stated that on 21 January 1999 he had a telephone conversation with Mr Gardner and discussed the fire safety inspection of the hostel. He informed Mr Gardner of what the inspection would entail and that he would forward a copy of the letter he sent to the solicitors. He states that he completed a fax header and confirmed that there was no need for Mr Gardner to concern himself over the process. This was to reinforce his earlier conversation that the building was well maintained and he didn't foreshadow too many problems with the inspection.

Mr Newman stated that he did not hear further from Mr Gardner or any other person regarding the request for fire safety inspection.

Where on Earth Pty Ltd

In March 1999 Where on Earth Pty Ltd purchased the business from Viewleigh Pty Ltd. The directors of the company were John Dobe and Christian Atkinson. The purchase of the business was on a walk-in-walk-out basis.

In his interviews with police, Mr Atkinson stated that when they purchased the business, no inspections were carried out by the Council or the fire service. Solicitors acting on their behalf managed the transaction. He said that there was a contract conditional on searches being conducted however his solicitor informed him that it was going to take some time to receive a certificate of inspection. Mr Atkinson confirmed in his interviews that this information was conveyed to Mr Gardner who was unhappy at the prospect of delay. Mr Gardner told them that the hostel had all the necessary fire safety equipment and that as far as he knew there was no fire safety certificate.

Mr Dobe stated in his interviews with police that when he and Mr Atkinson took over the hostel they had been given some instruction on the alarm system by Mr Gardner. He stated that Mr Gardner had informed them that when an alarm went off you check where it was alarming and check the detector by opening it up and cleaning it of dust or insects.

Mr Dobe recollects that in November 1999 they experienced further problems with the alarm which they were unable to isolate and cleaning didn't fix the problem. As a result of this they engaged Mr Geoff Jarrett to look at the problems. He recalls Mr Jarrett removing the control panel and sending it to Brisbane for repairs.

Mr Dobe states that they had no further alarm problems until March 2000 when they again contacted Mr Jarrett to come and fix the problem. He states that Mr Jarrett was able to rectify the problem on that occasion.

The next time problems were encountered was around April/May 2000 so Mr Jarrett was again contacted to come and fix the problem. A few days after this the problem started again. Mr Dobe stated in his interviews that they were unable to isolate the problem and when reset, the alarm continued to sound.

Mr Dobe said that the alarm system was then turned off so it wouldn't false alarm. He went to Mr Jarrett's home and asked him to come and fix the alarm system. He states that Mr Jarrett told him that he would ring them and come around the next day. He states that they never saw Mr Jarrett after that despite attempts to contact him.

Mr Atkinson confirms Mr Dobe's recollections of the events.

The evidence is that some time between 15 and 26 May 2000 the alarm system was turned off.

As we know the fire alarm system had been installed in 1993 by Mr Moore the original operator of the hostel. The evidence is that the alarm system had a history of malfunctioning from early in the period after Mr Dobe and Mr Atkinson took over the business. Mr Jarrett attended to see if he could establish what the problem was with the system. He freely admitted in evidence that as an electrician he was not an expert in electronics and advised that the units would need to be sent away for repairs. For that purpose he took both units (the W52 and W54) from the wall in the office and sent them to Tyco Services in Brisbane under cover of letter dated 22 September 1999. Mr Jarrett recalled that these items remained with the repairers for an extended period. He recalls speaking to someone at Tyco Services trying to chase up the repairs. He ultimately received the units back he thought just before Christmas 1999. The invoice from Tyco Services is dated 22 December 1999. Mr Jarrett reinstalled the alarm system at the hostel after the Christmas break in early January 2000. The system was then operating correctly. The repairs were carried out at a cost of $280.00.

Mr Scott McElwaine of Tyco Services recalled in evidence that the repairs in 1999 involved a stuck toggle switch on the W54 panel. Unfortunately, there is no documentary record of what work was carried out and Mr McElwaine had no recollection as to what other, if any, work was carried out in respect of either the W54 or W52 units.

Mr McElwaine thought that the repairs had been carried out reasonably quickly and the system had been sent back to Mr Jarrett on 9 November 1999. The evidence is unclear as to why, if that was the case, it was not reinstalled by Mr Jarrett until early January 2000.

There was no replacement system installed for the period the alarm was being repaired in Brisbane. This is in contrast to the situation when the alarm had been sent away for repairs in 1997 and temporary stand alone smoke alarms had been installed in the hostel by agreement between Mr Jarrett and Mr Gardner.

The system operated satisfactorily until shortly before 15 May 2000 when Mr Jarrett was again asked to affect repairs. On this occasion Mr Jarrett was able to trace the fault to an individual alarm in room 12. He cleaned the alarm and the system was again operational.

Mr Jarrett recalled that about ten days later when Mr Dobe came to pay his account he was again requested to repair the system. He advised Mr Dobe to make some attempt to isolate the problem since in the absence of the system alarming when Mr Jarrett was in attendance it would be virtually impossible to isolate the problem. Mr Jarrett's understanding was that Mr Dobe was going to make some attempt and then contact Mr Jarrett if the problem could not be isolated. Mr Jarrett heard nothing further from Mr Dobe.

Mr Dobe's recollection, taken from his police interviews, is that he requested that Mr Jarrett attend to see if the fault could be fixed and when Mr Jarrett didn't attend Mr Dobe made unsuccessful attempts to contact Mr Jarrett. Mr Jarrett's evidence was that throughout this period he lived in a house from where his business was conducted which was about 150m from the hostel.

When the alarm was not repaired Mr Dobe and Mr Atkinson decided to turn it off rather than have it continue to malfunction and false alarm. It remained off at the time of the fire on 23 June 2000.

On 22 May 2000 Mr Dennis Green from Berajondo inspected and serviced the fire hoses, reels and extinguishers at the hostel. While there he was asked for a quote for a new alarm system.

Mr Green's employer, Mr Terry drew up a quote dated 7 June 2000 in the amount of $12,000.00 and hand delivered it to the operators.

Fire Safety Inspections

A number of former members of the Childers Auxiliary Fire Brigade gave evidence that they attended the hostel to familiarise themselves with the layout. These inspections did not involve the testing of any fire safety equipment.

These activities are completed as a part of the QFRA community service and are conducted to familiarise themselves with large buildings including hotels, hospitals and the backpackers. They were meant to be conducted on an annual basis to inspect for significant risks and to recommend appropriate fire safety programs. These inspections are not carried out by qualified fire safety officers and their advice and recommendations are only of a general nature and are not enforceable.

Lieutenant Richard Randall conducted an inspection just prior to the new lessees (Where on Earth Pty Ltd) taking over in March 1999. Lieutenant Randall inspected the kitchen and various rooms and accommodation at the hostel. He indicated to Mr Gardner that the number of people in some of the rooms and personal property presented an evacuation problem. He also

observed barred windows. Mr Gardner informed him that it was for security purposes to prevent people trying to get in late at night. It seems that the only accommodation room with bars on the windows was room 7.

Lieutenant Randall further states that he inspected the fire evacuation plan which was attached to the reverse of the doors. He also inspected a large dormitory on the lower level of the building and he expressed concern to Mr Gardner regarding the number of people accommodated there and the placement of bunks.

Lieutenant Randall also inspected the hydrants and the evacuation points. He suggested to Mr Gardner that a possible evacuation point might be via the front verandah.

5.3 The circumstance/condition of the hostel in June 2000

In 2000 the Palace Backpackers Hostel was operated as a 'working hostel' rather than a 'holiday hostel.' Most backpackers were employed as fruit pickers on various farms within the Childers district and would often stay for lengthy periods.

Both Messrs Atkinson and Dobe were managers of the hostel and lived on site. The manager's accommodation was on the upper A Block of the building. Mr Dobe occupied one room with his girlfriend Jenny Hancock and Mr Atkinson occupied the second room.

The hostel was mainly fitted out with bunk style bedding constructed of pine and high-density foam mattresses. The bunks were stacked double and sometimes triple. Other rooms in the premises included the office area, containing mainly timber office furniture and general office items such as a computer, photocopier and business records. Also in the room were two pine dining tables with bench seats.

The general fire load of the hostel was significant taking into account construction, furniture type and occupancy levels.

At the time of the fire, the maximum occupancy was approximately 101 persons based on 99 beds. There were 17 accommodation rooms plus a ground floor dormitory, a manager's room with a double bed, private room, and an atrium area room located above a toilet which also had a double bed.

On 24 March 2000 Mr Robert Paul Long arrived by bus in Childers and moved into the Palace Backpackers Hostel. Between 26 March 2000 to 13 May 2000 he was employed to pick small crops at farms in the area. He appeared reliable and socialised at a number of the hotels in the Childers area.

On 14 June 2000 at 7:00 pm Mr Long was sighted in Churchill Street Childers after leaving a suicide note at the Federal Hotel. The details of the note were provided to the Childers Police who attempted to locate Mr Long. Between 16

June 2000 and 23 June 2000 there were numerous sightings of Mr Long in and around Childers main street. Most sightings were at night.

On 14 June 2000 Mr Long left the hostel owing money. There appears to be no further involvement of Mr Long with the Hostel until 19 June 2000 when a further suicide note from him was located from under the front door of the hostel.

5.4 The events of 23 June 2000

On the evening of 22 June 2000 88 people were accomodated at the hostel: 85 guests plus the operators Mr Dobe and Mr Atkinson and Mr Dobe's girlfriend.

A list of the rooms occupied by various hostel guests is set out below.

Room 1	Boyle, O'Donahue, Baker, Waldek, Griffen
Room 2	Gora, Kim, Visser
Room 3	Mahoney, **Van der Velden (deceased), Lee (deceased)**
Room 4	Gutteridge, Teeuwen
Room 5	Grindley, Pou, Kubo
Room 6	Cutler, Shimikoda, Griffith, Lo, **Westerveld (deceased), Rowland (deceased)**
Room 7	**Morris (deceased), Williams (deceased), Lewis (deceased), Sutton (deceased), O'Keefe (deceased), Smith (deceased), Webb (deceased), K. Slarke (deceased), S.Slarke (deceased), Toyona (deceased)**
Room 8	Dinning, Paton, Lundgren
Room 9	Moffat, Ngatai
Room 10	Cockhill, Duffy
Room 11	K. O'Brien, Symonds
Room 12	Tempest, Tomar, Yeung, **Lalaoui-Kamal (deceased)**
Room 13	Berendsen, Knudslien, L. Morris, K. Morris
Room 14	Hasegawa, Henry, Obika, Parker
Room 15	Burghout, Dekort, Telfer, Vaughan
Room 16	Dalidowicz, Matsushima, Sekido, Weigand

Room 17	Bolt, Whitehouse
Dormitory	Baird, Cameron, Campbell, Dekleer, Dekker, Farrell, Hay, Hill, Jansen, Keen, Korner, Leech, D O'Brien, Morgan, Spear, Sipavicius, Post, Renders, Terra, Van Zelst.
Atrium Room	Pillans, Martin

At about 10.00pm that night Mr Long was seen to be sitting at the internet kiosk under the atrium stairs.

Mr Long had a conversation with two backpackers, Mr Martin Cockhill and Ms Lisa Duffy at the rear of the hostel before they went to bed at between 11.50pm and 12.00pm. During the conversation Mr Long made threats that he wanted to "bash" a backpacker, Mr Vishal Tomar, whom he didn't like. He also asked them to leave the back door to the hostel open so he could get in and carry out this assault. He also told them that he had a key cut for the hostel. They left him sitting outside the rear of the hostel when they went to bed.

Ms Lauren Morris stated that she returned to the hostel at 10.40pm and went straight to sleep in her bed in room 13 on the southern side of the atrium on the first floor.

At between 11.50pm and 12.10am she awoke and walked down the internal stairs. She recalls seeing a male person at the internet machine. He was still sitting there when she returned towards her room. As she walked back past the door to the television room, she did not notice anything in the television room but commented on an odour that she described, as a stale smell that she didn't think was smoke. She did not see any flames.

She passed Mr Neil Griffith on the bottom of the steps when she was returning to her room. She again observed the male person still sitting at the internet machine. She went back to her room and was lying in bed awake for about five minutes when she heard banging noises coming from downstairs.

She then got up and one of her roommates opened the door to her room (13) and black smoke poured into the room. They all got down on the floor and crawled out of the back door of the hostel. She remembered that the floorboards were really hot. This doorway was on the southern side of the room leading out into a hallway running parallel to the atrium on the other side of the room. Smoke had filled this area within minutes of the fire being noticed.

Ms Catharina Berendsen was a roommate of Ms Lauren Morris in room 13. She returned to the hostel and went to bed in room 13 at 12.20am. She checked her battery operated alarm clock before going to bed and noticed the time.

A few minutes later, as she was falling asleep she heard a sound that she compared to popcorn popping and then windows smashing. She jumped out of bed and tried to turn the light on but it did not work. Clearly, the mains power had failed by this time. She opened the door and smoke rushed into the room. She was directed to get to her knees and felt someone's leg that she followed out onto the balcony.

Mr Griffith had been staying at the hostel in room 6 on the first floor. He recalls going to bed at about 11.00pm. He recalled waking about an hour later and went downstairs and saw a male person sitting at the internet machine. He recalled walking past Ms Morris who was just coming back and at this time he saw a male person sitting at the internet machine below the stairs.

He walked past the entrance to the T.V. lounge room and saw a black plastic bin on fire just inside on the left-hand side of the doorway. He went into the lounge room and could see that the dustbin lid was half off and that a lot of paper hand towels had been stuffed into it. There was some paper around the base of the bin as well. He also saw that one of the lounge square cushions was on top of the lid. He described this to be a bridge between the bin and the lounge.

He could see that the paper in the bin and on the floor was on fire. He picked up the lounge cushion and started hitting the fire with it in an effort to put it out. The fire appeared to fan so he placed the cushion back on the lounge. He noticed that the bottom of the cushion had been blackened but he stated that there was no burning or smouldering on the cushion. He saw that the burning paper on the floor was out but the paper in the bin was well alight. He couldn't find an extinguisher to put the fire out with. He recalled looking up at the ceiling in the hallway and wondering why the fire alarm had not activated.

He called out to the male at the internet machine, *"There's a fire in the bin in the lounge room."* The male then came over picked up the bin, which was starting to melt. He watched while the male exited the rear door of block C on the southern end of the complex with the burning bin. Thinking that everything was all right he then went back to bed.

A short time later he awoke to the sound of a noise and found that the room was filling with smoke. He got down onto the floor and crawled out of the room into the corridor on the northern side of the room which was full of smoke. He exited onto the front veranda and escaped.

Mr Darrin Hill was sleeping in the large dormitory on the ground floor. He was woken by the sound of smashing glass and he opened the door from the dormitory into the atrium on the southern side of the dormitory. He looked outside and found that the lounge and area around it were on fire. The kitchen wasn't on fire at this time. He could see flames and smoke. He then raised the alarm to the other backpackers in the dormitory and everyone escaped out the front door. Mr Hill went across the road to the pay phones in

Churchill Street and called triple 000 and reported the fire. The call to the fire service was recorded and shown to have been made at 12.32am.

Mr John Pillans was a resident of an atrium room above the toilet on the ground floor shared with his girlfriend Ms Lisa Martin. Mr Pillans is deaf without his hearing aid. They escaped from their room in the atrium via the external window into the laneway on the western side of the building. After they got out of their room Mr Pillans remembered looking at his watch and noting that it was between 12.20am and 12.25am. Before leaving the room, he opened the front door leading to the atrium. He saw black smoke billowing around and saw that the atrium stairway didn't appear to be on fire.

They went to the rear of the building where he found what he thought was a dustbin lid on fire. He put out the burning dustbin lid with a garden hose and then attempted to train the hose on the fire in the lounge room.

Mr Anthony Gora was staying in room 2 on the northern end of the first floor. He stated that on the Thursday night at about 10.00pm, he saw Mr Long sitting at the internet machine in the atrium area of the hostel. He knew Mr Long well from his time staying in the hostel. Mr Gora then went to bed. He stated that he was asleep in bed and he woke at 12.04am and looked at his watch. He remained awake and after ten minutes he was going to get up but it was too cold. Ten minutes later he heard banging and smashing windows. He got up to look around and went out to the verandah facing Churchill Street where he saw thick black smoke coming out of the corridor. He called out “fire” and then went back into his room and felt his door, which was warm. He opened the door and felt a wave of heat and saw lots of smoke. He tried to enter the corridor but it was too hot and the smoke was too thick. He couldn’t see any flames at this time.

Mr Scott Cutler was staying in room 6 on the northern side of the atrium on the first floor and was woken by the sound of breaking glass. When the door to the room was opened into the hallway on the opposite side of the room from the atrium smoke poured in through the opening. He stated that the smoke was thick and he escaped onto the front verandah.

Mr Mark Dinning and Mr Gary Paton both slept in room 8 on the southern side of the atrium on the first floor of the hostel. Mr Dinning was woken by the sound of breaking glass and popping plaster. When the door to the room was opened, he saw that the smoke was so thick that he could see nothing. The doorway in room 8 was on the western wall of the room and opened into the corridor which ran in a north/south direction. He crawled out of the room and felt intense heat in the corridor leading to the back door. Mr Paton also crawled out and in the corridor he turned towards the atrium to the north but had to turn back due to the heat. He escaped through the back door.

Mr Richard Tempest was staying in room 12 which was on the eastern side of the corridor leading to the back door on the first floor and he awoke at 12.40am to the sound of a noise. He looked at his watch at this time. He

listened and the noise got more frequent and louder. He could hear glass breaking so he got up and the door was opened and thick smoke was seen in the hallway. The door was near the southwest corner of the room and opened into a corridor running east/west into the main corridor to the back door. He crawled out to the back door and went downstairs. He saw a small ring of fire and noticed that the flames were fierce in the television room. He then walked around to the front of the hostel and a few minutes later the fire brigade arrived.

Ms Sam Telfer was the occupant of room 15 on the southeast corner of the first floor above the television room. She states she was awoken by noises described as like fireworks and windows smashing. She looked out the back window on the southern end of the building and saw flames coming from below the left eastern side of her room window. She crawled out of the room through the doorway which exited on the northern side of the room into a corridor which ran in an east/west direction before turning into the main north/south corridor leading to the back door at the southern end of the building. She crawled out on her hands and knees. She saw that the smoke was thick. When she got outside, she asked someone the time and was told it was 12.40am. She believed it to be ten minutes from the time she was awoken to this time.

Ms Sarah Mahoney went to bed in room 3 (immediately adjacent to room 7) at about 9.00pm. One of her room mates Ms Hui-Kyong Lee was already asleep in bed and the other Ms Joly Van der Velden was not there at that time. Ms Mahoney was woken by the sound of breaking glass and what sounded to her like small explosions. She jumped down from the top of the triple bunk and noticed that the other two girls were awake but still in bed. She could hear noises coming from room 7 as there were people in the room talking and running around but she couldn't understand what they were saying. She took hold of Ms Lee's hand and told her that they had to get out. She recalled that at this time there was no light and the room was filled with thick black smoke. She felt for the door handle and exited the room into the hallway on the northern side of the room on the side opposite the atrium. She called out for the other girls to follow her. She could not see or breathe and holding her breath got down on the ground on her hands and knees, turned right and crawled along the hallway using the wall as the only means of feeling her way. She turned right again into the passageway which led her in a southerly direction back towards the atrium. She continued to crawl in this direction until she reached the intersection of that passageway with the atrium and at this point raised her hand and received burns to her palm and the tops of her fingers from the extremely hot air. At this point she realised that it was impossible to go any further in this direction and turned back where she found other people who had been following her along the corridor on their hands and knees. They went together in a northerly direction away from the atrium and finally exited to safety on the front veranda. Ms Lee was later found deceased in the hallway not far from where she had exited room 3 with Ms Mahoney.

Both operators were awoken in the early hours. They escaped the building onto the front verandah facing Churchill Street. The smoke and heat made it impossible for them to re-enter the building to assist other backpackers in making their escape. They weren't aware of the time that they were awoken, but they recall being on the front verandah when the occupants escaped the downstairs dormitory and they saw Mr Hill run across the road to the phone box.

They eventually escaped onto the roof of a neighbouring shop and were rescued by fire fighters.

5.5 The emergency response

The first triple 0 call was made at 12.31.55 am by Mr Hill. A further four calls were registered shortly after. Three of the calls were made at 12.32 am by residents of Churchill and Macrossan Streets. Another call registered at 12.47 am from a resident in McIlwraith Street. All callers to Firecom reported hearing loud noises or seeing flames.

Queensland Fire and Rescue Authority

The first attending unit was appliance 913 from Childers Station. The crew was an on call auxiliary fire crew with Lieutenant Richard Randall in charge. The other members of the attending crew were Mr Robert Winkleman, Mr Curl Santacaterina and Mr Hayden Whitaker.

The first crew arrived on the scene at 12.38am. They reported that upon arrival black smoke was pouring out from under the verandah and the windows at the side of the building. A flickering of orange could be seen on the lower floor of the hostel.

Firefighters Winkleman and Santacaterina were instructed to don breathing apparatus and to enter the building to search and rescue. They entered the building through an external doorway into the large dormitory. They crossed the room to another doorway that gave access out onto the atrium area. These doors were closed and they could see a glow through the windows above the door.

When they opened the doors a great deal of fire was observed in the television lounge room. The fire appeared to have been coming from within this room.

They then began to fight the fire from this position. They directed a stream of water onto the stairway leading to the first floor in an effort to maintain it as an escape route.

While this was occurring Firefighter Whitaker put a ladder up to the buildings on either side of the hostel and assisted to safety those who had gathered there.

A short time, later at about 12.50, am Firefighters Winkleman and Santacaterina were withdrawn by the fire commander Lieutenant Randall because the fire had been seen to flashover on the upper level. Lieutenant Randall explained that involved super heated gases which accumulated in the atrium exploding as they sucked in oxygen which then further fed the fire. He said the wall of flame that this produced burst out over the front of the hostel, over the footpath, and over the fire appliance. Sheets of orange and red flame and exploding glass were observed to emanate from the upper front of the building.

After this happened it was apparent that the fire was consuming the upper floor at the front of the building and it was therefore unsafe for Firefighters Winkleman and Santacaterina to remain in the building. They adopted a defensive action of suppressing the fire. This meant that they were protecting the exposures of the building and preventing fire spreading to neighbouring businesses.

Other members of the Childers Auxiliary Fire Service were paged to attend at 12.32am. Mr Martin Betteridge and Ms Melinda Ratcliffe attended the front of the building and assisted at the main entrance. When the front door was opened they saw the building erupt in flames.

The Auxiliary Crew then attended the rear of the building and attempted to suppress the fire from this location.

A crew from Bundaberg appliance 112 attended the scene and arrived at 1.11am. They assisted in the suppression of the fire by positioning the crew in the area between the hostel and the adjoining buildings.

Mr John Watson, Area Director, QFRA arrived on scene at about 1.10am on the morning of the fire. He assumed control of all fire fighting operations from 1.30am. He stated that Lieutenant Randall advised him that an attempt had been made to enter the building through the lower floor dormitory but heat and flames had driven out the search team.

As a result of considering the evidence of those who participated in the events of that night and the expert evidence of other senior fire officers who have reviewed the operation, I am satisfied that the Firefighters involved performed to the highest standard that could be expected. No lives were lost due to their conduct, indeed had it not been for their prompt and courageous actions many more could have died.

5.6 The QPS response to the arson

At 12:50 am Sergeant Geoff Fay of Childers Police was advised of the fire and attended at the scene. His tasks included attempting to maintain the safety of survivors and controlling the scene to assist the Fire Officers.

Due to the enormity of the incident Sergeant Fay called out members of the Bundaberg CIB to assist in the investigation.

He spoke with a number of the survivors and the managers of the hostel. He also spoke with Neil Griffiths who identified to him that he had observed the bin on fire in the TV/Lounge room.

He also had a conversation with Ms Lisa Duffy. Ms Duffy reported that the fire was not an accident and she believed that Mr Long was responsible for the fire. She relayed to Sergeant Fay the events of the evening and the conversations that she and Mr Cockhill had with Mr Long.

Sergeant Fay then set about compiling a list of the survivors. It had become evident from speaking to survivors that a number of the occupants were missing.

At 1:00 am Detective Senior Constable Williams, Plain Clothes Senior Constables Brabham, and Bubb of the Bundaberg Criminal Investigation Branch (CIB) were recalled to duty to assist in the investigation.

The CIB members then set about conducting a reconciliation of survivors and roll call to ascertain the possible identity of the missing persons.

Police then attended the location and obtained witness statements. General duties police performed scene security and provided assistance to QFRA as required.

Later in the morning further plain clothes and general duties police were dispatched from Bundaberg, Childers, Gin Gin and Maryborough to assist in general investigations and scene security.

A statement taking room was set up in the Childers Cultural Centre to provide a private area free from interruptions for the taking of statements from all backpackers and witnesses.

Expert assistance from the Homicide Squad and Arson Squad was requested. Both squads responded and deployed investigators to the area.

The police response was well co-ordinated and professional.

5.7 Disaster Victim Identification

Obviously when people die in conflagrations such as occurred at the Palace Backpackers Hostel on the night in question, identification by the usual means, namely visual, dental or finger prints is not possible. In these cases a specialist process is undertaken by the Disaster Victim Identification Squad (the DVIS). Their processes conform with international protocols regulating such matters.

The role of the DVIS is to attend at major incidents, accidents, air disasters and natural disasters and to remove the remains of victims of such events and coordinate the reconciliation process which is used to facilitate positive identification of the deceased persons.

It became apparent soon after the fire was brought under control that these procedures would be necessary in this case. Accordingly the DVIS was dispatched from Brisbane.

Once the remains were located their position in the building was logged and a unique number given to each body. A temporary morgue was set up outside the hostel to preserve the dignity and forensic integrity of the bodies.

The bodies were transported to the John Tonge Centre (JTC), Kessels Road, Cooper's Plains.

Post-mortem examinations were conducted on the bodies at the JTC in line with normal protocols and procedures. Evidence from all sources including dental, physical, circumstantial and DNA were accumulated in relation to each body.

DNA, dental records and personal items were used to identify Kelly and Stacey Slarke.

Extensive inquiries were conducted with the Department of Immigration and Foreign Affairs to identity a Moroccan national, Moulay Lahcen Lalaoui-Kamal.

The DVI Identification Board met and considered the results and made recommendations to the coroner. I have reviewed the results of that process and I am satisfied that they have accurately identified each of the bodies recovered from the fire scene.

5.8 Autopsies

Autopsy examinations were conducted on 28 and 29 June by Professor Ansford, Associate Professors Naylor and Williams, and Dr Sinton.

Autopsy examinations indicated that the cause of death for all deceased was 'smoke inhalation' due to fire. Due to the extent of damage of some of the deceased no evidence of trauma could be detected. More detail of the autopsy findings is contained in Section 6.

5.9 Criminal investigation and prosecution of Robert Long

Investigations established that on 22 June 2000 at 1:14pm Mr Long used an EFTPOS transaction at Childers Hotel to purchase a cask of wine.

At 8:00 pm the same date Mr Gora observed Mr Long on internet machine under stairs in hostel. At 8:40pm Mr Tomar observed Mr Long in the hallway near the internal stairs. Mr Tomar watched Mr Long from his room as he walked around the hallway. Mr Long departed after seeing Mr Tomar watching him.

At 10:45 pm Ms Amy Baker observed Mr Long looking around on the bridge area of the top floor. Ms Baker queried something that Mr Long said. Mr Long

replied, "Not talking to you". At 11:55pm Ms Duffy and Mr Cockhill spoke to Mr Long at the back of the hostel. Mr Long was carrying a brown beer bottle and wine cask. Mr Long asked them to leave the rear fire escape door open.

It will be recalled that at about midnight Mr Griffith's gained assistance from Mr Long in removing the burning bin from the T.V. room.

In the five days following the fire Mr Long was seen on at least six occasions in and around the Childers area.

At 12:30am on 23 June 2000 truck driver Mr Fred Bellows and passenger observed a male person come out from the doorway of the hostel and walk quickly across the main street towards the bank. The person matched Mr Long's description and was carrying amber bottle and wine cask.

At 4:10pm on 28 June 2000 Special Emergency Response Team (SERT) operatives and a tracking dog picked up a scent on the Old Bruce Highway near Burrum River Bridge. The tracking lasted for 300-400m and then went through scrub to edge of bush line and through lantana.

Mr Long was then located near the edge of riverbank. SERT operatives attempted to arrest Mr Long and Mr Long attacked one of the operatives with a knife stabbing him in the jaw. A struggle between the operative, Mr Long and the police dog ensued. During the struggle the other SERT operative drew his firearm and shot at Mr Long. Mr Long was injured in the ear as a result and the struggle ceased. At the time that the struggle ceased Mr Long stated "I'm dying anyway, I started the fire."

Mr Long appeared in the Bundaberg Magistrates Court on 18 August 2000 charged with the murder of two of the hostel residents, sisters Kelly and Stacey Slarke, in addition to the arson of the hostel.

A committal hearing proceeded in the Brisbane Magistrates Court before Mr Halliday SM between 02 and 13 January 2001. Mr Long was committed for trial on all charges.

Subsequent to considerable negotiations regarding the location of the trial, the matter commenced in the Brisbane Supreme Court on 18 February 2002 before Justice Dutney. Some 60 witnesses gave evidence at the trial.

On 15 March 2002 the jury returned guilty verdicts on all charges. He was subsequently sentenced by His Honour Justice Dutney on 18 March 2002 to life imprisonment for the murders of Kelly and Stacey Slarke, with a non-parole recommendation of 20 years, and to 15 years imprisonment for the arson of the Palace Backpackers Hostel.

Two applications were then filed in the Court of Appeal. Mr Long appealed against his convictions for the murders and arson and the Attorney-General appealed against the sentence imposed on Mr Long. The applications were

heard on 29 and 30 October 2002. The Court of Appeal dismissed both applications on 28 February 2003.

Mr Long then applied to the High Court of Australia for special leave to appeal. The application was argued and refused on 23 June 2004

5.10 The results of the technical investigations

The prosecution of Mr Long established who started the fire. More technical investigations were required to understand how it so quickly engulfed the hostel and caused such a terrible loss of life.

5.10.1 The QFRA Reports

Fire Incident report

This report assessed the management of the incident. The report states that following multiple calls to Firecom North Coast, a fire communications centre located at Kawana, fire crews from Childers and Bundaberg, urban and rural, arrived to assist. The first fire fighters were on the scene in less than eight minutes of receiving the initial notification.

Fire fighters were confronted with heavy smoke when they arrived and they observed a number of occupants escaping the building to adjoining rooftops. Evacuees and bystanders had gathered at the front of the building.

The initial action taken by QFRA was to rescue occupants reported as missing. A crew was dispatched with breathing apparatus and a single hose to attempt this. It soon became apparent that this activity was not safe and the instruction to undertake a defensive firefighting action was given.

The report resolved that there were a number of issues which impacted upon the extraordinary loss of life. It identified the following matters:-

- density of occupancy;
- type of construction/age of building which contributed to the rapid spread of fire;
- lack of early warning to the occupants;
- inadequacy of fire safety installations within the building;
- loss of structural soundness of the building which restricted access by firefighters; and
- means of escape from rooms on the first floor.

The report concluded that the loss of life could have been significantly reduced with adequate, properly maintained fire safety features such as operative early warning systems and residential sprinkler systems. The reports authors consider that if features such as these had been in place they would have enabled the occupants to make their way to a place of safety.

The Fire Investigation Report

This report examined the cause and origin of the fire. It was identified as an open flame and not a smouldering ignition factor. The exact point of origin of the fire was not able to be established. However, it was identified that the most likely point was within a two metre radius of the centre of the northern wall of the area of origin which was the television lounge room in block B.

Testing indicated that the simultaneous ignition of two or three (not just one) large pieces of upholstered furniture would have been required to develop conditions that enabled the fire to progress as rapidly as it did.

The report observed that shortly after the fire started smoke entered the atrium that divided blocks A and B, through a door and window which opened into the atrium. Smoke then entered the first floor of block B through an open doorway. This doorway allowed access to a walk-over bridge to block A. Smoke and super-heated gasses then accumulated in the atrium igniting the timber structures supporting the roof of the atrium. The fire developed rapidly in the television lounge room downstairs intensifying the heat release and smoke development. The fire spread rapidly due to the fire load.

The products of combustion then entered blocks A and B through open doors on the atrium side and through windows after the glass panes failed from the intense heat. Flash over occurred in the television lounge room, first floor block B and the south east side of block A.

The design features and height of the ceiling in the corridor of block B assisted in funnelling the fire towards the atrium. The combustibility of the furniture and internal structural members greatly assisted the surface spread of the fire and the amount of toxic smoke produced in the growth stage of the fire.

The report also identified the following factors which may have contributed:-

- the smoke alarm system was disabled prior to the fire and an electrical fault existed in the connection point within the alarm panel. The electrical connection was tested and was found to have been corroded by water;
- illuminated exit signs did not function correctly when the mains power supply failed. It appeared that the backup battery had not been changed since the installation of the signs in 1993; and
- security bars, obstruction of some of the doors from bedrooms by beds etc and the combustibility of the furnishings reduced the amount of safe exit time from the bedrooms to a place of safety. The smoke produced from the materials created toxic fumes which would have contributed to the deaths of the occupants and limited the visibility of those evacuating the building.

This report similarly concluded that the loss of life could have been significantly reduced by an operating smoke alarm system or the installation of

an automatic fire sprinkler system, combustion modified furnishings and ground level exit lighting.

Building Fire Safety Report

This report analysed legislation current at the time. It found that although the hostel had exit signs, emergency lighting, fire hose reels, fire extinguishers and a fire detection and alarm system. The majority of these systems were not fire safety installations prescribed by local government. At the time of the fire not all of these systems were operating or had been adequately maintained.

The provisions of the *Fire and Rescue Authority Act 1990* applicable at June 2000 did not require non-prescribed fire safety installations to be maintained. Accordingly, the report recommended that the Act be amended to require prescribed and voluntarily installed fire systems to be maintained to Australian or manufacturer's standards.

Amendments were also recommended to the formula in the *Building Fire Safety Regulation* to ensure that occupancy numbers in accommodation buildings would be clearly defined. All aspects of a building, not only health and amenity issues, should be taken into consideration. It was suggested that the formula should include storage facilities for personal items of the occupants and adequate clear space between beds.

It was the opinion of QFRA officers that the density of beds and occupants in rooms was a factor which contributed to the loss of life.

The report concluded that under legislation in force at the time of the fire, unless building approval or a change in classification was required, existing buildings used as budget accommodation were not required to upgrade fire safety.

It observed that a building application was submitted to the Isis Shire Council in 1993 for an extension to the rear ground floor (block C). While a certificate of classification was issued for the extension, no change of classification or drawings were submitted to the council for the remainder of the building. It was possible that the fire load increased substantially through an increase in occupancy numbers and furnishings.

Another issue examined in the report was security versus safety. Security measures were evident in both ground and first floor areas of the building. Metal security bars were fixed to some of the windows and a number of doors in the ground floor 25 bed dormitory were unable to be rescued as a result of being fixed closed.

The nominated means of escape was through the normal access into the atrium and then into the hallway which led to the required exit door. A combination of the late notification of the fire and the rapid production of

smoke and heat caused this means of escape to become untenable. The installation of suitable fire safety systems within the building would have allowed adequate time for all occupants to be warned of smoke and/or fire and escape therefore possible.

Summary of findings of the QFRA Reports

1. The investigations have established that the area of origin of the fire was within the ground floor room designated television lounge room in Block B. This is where Long lit multiple small fires which spread rapidly into the atrium area dividing Blocks A and B.

2. Thick toxic black smoke entered the atrium area and progressed rapidly up to the first floor where it entered Blocks A and B from the atrium side of those blocks. Smoke and super heated gases accumulated in the atrium ultimately igniting the timber structures which supported the roof of the atrium.

3. The fire spread rapidly as a result of the fire load that is the quantity of furnishings and personal possessions throughout this area.

4. The design features and height of the ceiling in the corridor of Block B assisted in funneling the fire towards the atrium of the building.

5. The absence of an operating fire alarm system prevented early warning to the occupants of the hostel of the development of the fire and smoke.

6. Illuminated exit signs did not function correctly when the mains power failed as apparently backup batteries fitted in the signs had not been changed since their installation in approximately 1993. This in turn impeded those attempting to safely exit the burning premises.

7. Occupants attempting to evacuate may have been further impeded by the blockage of some of the doors of the bedrooms by beds and personal possessions together with the installation of security bars on some windows.

8. In the opinion of the QFRA Building Fire Safety Officers, the density of beds and occupants in rooms was a factor that contributed to the loss of life.

9. The QFRA investigation concluded that when in 1993 a Building Application was submitted to the Isis Shire Council for an extension to the rear of the ground floor to add an ablutions block, no change of classification or drawings were submitted to the Council for the remainder of the building. This had the effect that the fire load was increased substantially through the building as a whole by virtue of the increase in occupancy numbers and furnishings.

10. Furthermore and perhaps more significantly, there was no change of classification of the premises when it was first converted to a backpacker's hostel in 1993. Mr Hartnett's evidence was that this was not necessary, in his view, because the proposed use came within the terms of the building's then current classification of 3. The dormitory area on the ground floor was always proposed to be used by Mr Moore for accommodation. As mentioned elsewhere in this report, the bathroom on the first floor was converted for use as accommodation as room 7 during the time Mr Gardner was operating the business.

11. Ultimately the QFRA Investigations conclude:-

> *"the nominated means of escape was through the normal access into the atrium and then into the hallway which led to the required exit door. A combination of the late notification of the fire and the rapid production of smoke and heat caused this means of escape to become untenable. The installation of suitable fire safety systems within the building would allow adequate time for all occupants to be warned of smoke or fire and escape before the paths of travel become untenable."*

5.10.2 Electrical Safety Office Report

The examination of the electrical installation and equipment within the complex was made difficult due to the extent of the damage sustained.

The pattern of damage in the television lounge room indicated the origin to be located towards the centre of the room.

There was no electrical equipment found in this location that would have resulted in a failure or malfunction likely to cause an ignition therefore the fire did not originate as a consequence of any failure, breakdown or malfunction of the electrical equipment or installation.

The expert evidence is that the alarm system was rendered potentially inoperative because of a fault due to corrosion of pins in the connecting cable within the W52 unit.

A major issue for the investigators was why the fire alarm had so consistently caused problems that the operators switched it off. Experts from the QUT School of Electrical & Electronic Systems Engineering examined all components of the alarm control panels and wiring system. They found that that the system battery in the W52 unit was unable to be recharged because of the corroded pins referred to earlier. That was a critical fault since the W52 unit was designed to convert the mains power through to the backup battery which in turn was the means by which the alarm system was actually powered. When the back up battery could not be continually charged it meant that the system would quickly run out of power. It is not possible to know whether if the alarm system had been turned on as at the time of the fire on

23 June 2000 it would have had sufficient power remaining in the back up battery to power the system to give early warning of the fire.

5.10.3 Computer modelling report

The QPS and QFRS commissioned a report from consulting engineers modelling the course and path of the fire. The report indicates that the origin of the fire was the television/lounge room. It concluded that the simultaneous ignition of two or three large pieces of upholstered furniture was required to develop conditions that were experienced when the fire engulfed the building.

This supports the theory of the scientific and forensic examiners that the fire was not a smouldering, accidental fire but one caused by the deliberate application of open flame.

6. Findings required by s43 – particulars of deaths

I am required to find, so far as has been proved, who the deceased were and when, where and how they came by their deaths.

As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings.

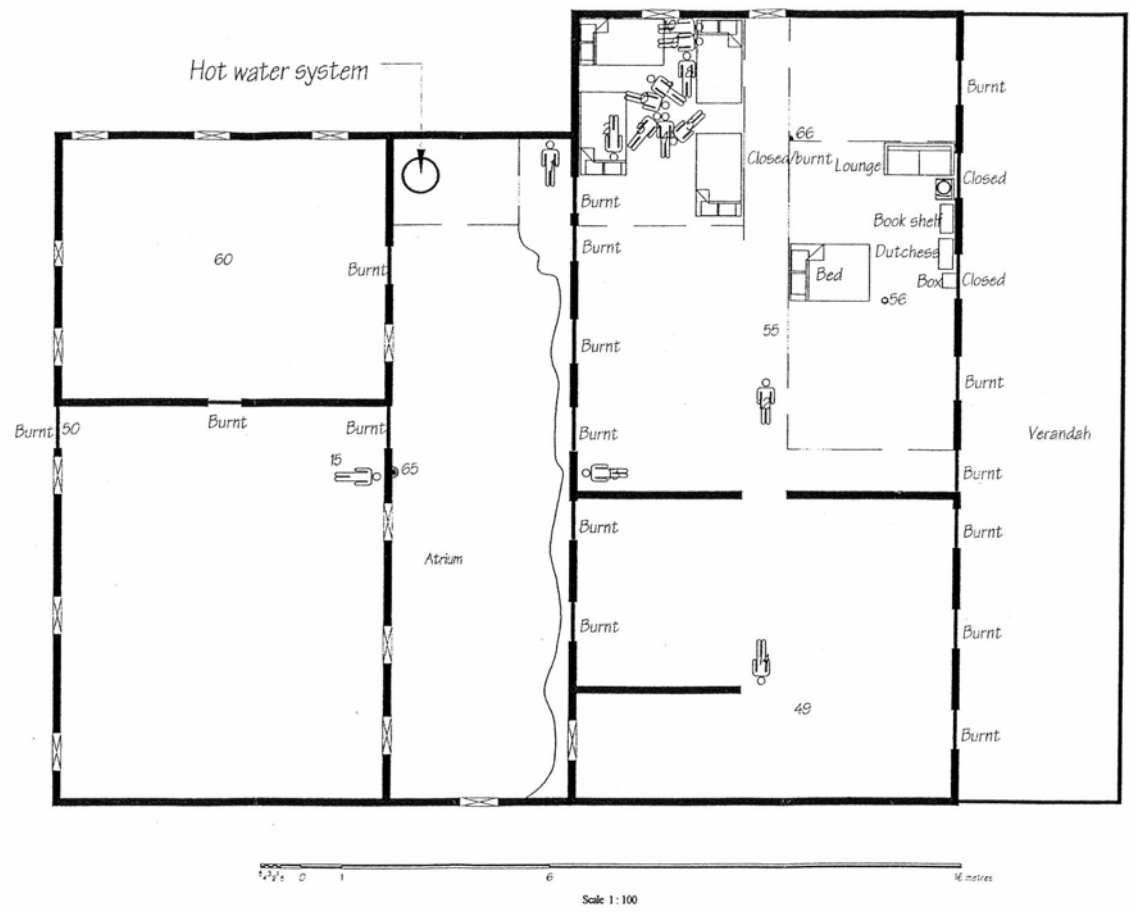
Identity of the deceased

DVI NO.	NAME	AGE
1.	Sebastian WESTERVELD (M) Holland	22
2.	Sarah Anne WILLIAMS (F) England	23
3.	Michael Ernest LEWIS (M) England	25
4.	Clare Louise WEBB (F) England	24
5.	Natalie MORRIS (F) England	18
6.	Gary John SUTTON (M) England	24
7.	Melissa Jane SMITH (F) England	26
8.	Atsuski TOYONA (M) Japan	31

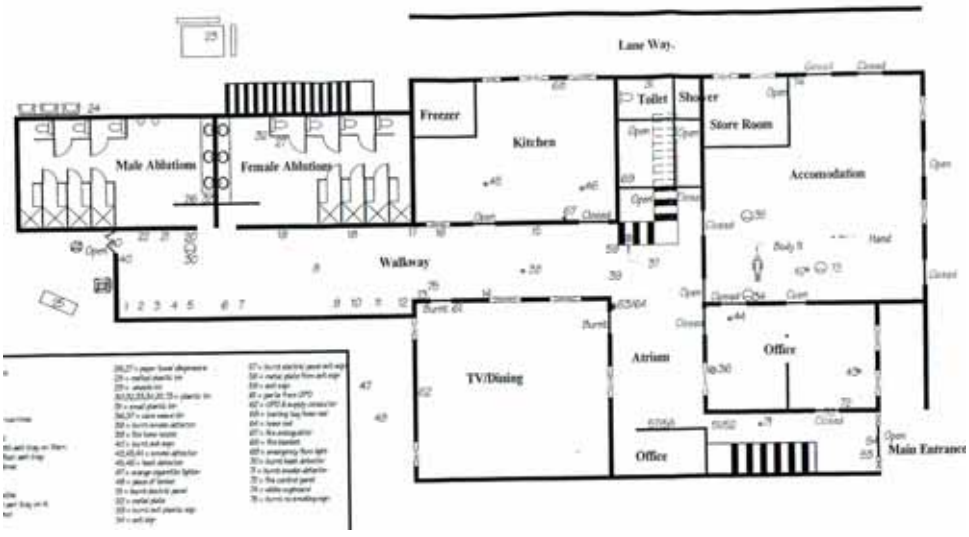
9.	Stacey Louise SLARKE (F) Australia	23
10.	Julie O'KEEFE (F) Ireland	24
11.	Joly VAN DER VELDEN (F) Holland	23
12.	Hui-Kyong LEE (F) Korea	23
13.	Adam John ROWLAND (M) England	19
14.	Kelly June SLARKE (F) Australia	22
15.	Moulay Lahcen LALAOUI-KAMAL (M) Kingdom of Morocco	48

Place of death

All deceased died in the Palace Backpackers Hostel situated at 72 Churchill Street, Childers.



TOP FLOOR



GROUND FLOOR

Sebastian Westerveld died in the large dormitory on the ground floor.

All the other deceased were located on the first floor in the following locations:-

Sarah Williams, Michael Lewis, Clare Webb, Natalie Morris, Gary Sutton, Melissa Smith, Atsuski Toyona, Stacey Slarke and Julie O'Keefe all perished in room 7.

Joly Van der Velden died on the landing outside room 7. Hui-Kyong Lee died in the passageway outside the manager's accommodation. Adam Rowland died in the room 6. Kelly Slarke died in the passageway near the internal stairs on the eastern side of block A. Moulay Lahcen Lalaoui Kamal died in room 12.

Date of death

All deceased persons died on 23 June 2000.

Cause of death

All deceased died of smoke inhalation due to fire.

Smoke inhalation occurs when you breathe in the products of combustion during a fire. Carbon monoxide is a chemical produced as a result of combustion. Carbon monoxide poisoning is the usual mechanism of death in fatal smoke inhalation in a house fire. Carbon monoxide combines with haemoglobin resulting in carboxhyaemoglobin. Most victims succumb to the asphyxia effect of carbon monoxide long before the flames and heat affect the body.

Blood taken at autopsy is analysed for carbon monoxide content and the result expressed as a percentage of the haemoglobin which is saturated with carbon monoxide. The lethal concentration of carboxyhaemoglobin saturation is generally considered to be greater than 50% although individuals with pre-existing cardiac or pulmonary disease may succumb at lower levels of 30-40%.

The toxicological results revealed the following levels of carboxyhaemoglobin levels:-

Natalie MORRIS	84%
Sarah Anne WILLIAMS	75%
Sebastian WESTERVELD	71%
Clare Louise WEBB	69%
Melissa Jane SMITH	69%
Hui-Kyong LEE	69%
Gary John SUTTON	68%
Michael Ernest LEWIS	67%
Julie O'KEEFE	64%
Atsuski TOYONA	63%
Kelly Jane SLARKE	61%

Joly VAN DER VELDEN	57%
Adam John ROWLAND	56%
Stacey Louise SLARKE	54%
Moulay Lahcen LALAOUI-KAMAL	46%

7. The Committal Question

Insofar as it is relevant to this case, the Coroners Act provides in s41(1) that if a coroner holding an inquest into a death, considers that the evidence is sufficient to put a person on trial for murder or manslaughter, the coroner may order that the person be committed for trial.

It is not my role as Coroner to decide whether any person is guilty of an offence in connection with the deaths of the 15 people who died in the fire or indeed, even whether the prosecutorial discretion should be exercised in favour of presenting an indictment and bringing the matter before a jury. Rather, I only have jurisdiction to determine whether anyone should be committed for trial. That requires I consider whether a properly instructed jury *could,* on all of the evidence presented at the inquest reasonably convict any person of any of the offences that are raised by the evidence.[9]

In my view, the circumstances of this case require me to consider whether the operators of the hostel should be committed to stand trial on charges of manslaughter.

The ten occupants of room 7 blamelessly died when they were denied early warning of the fire after the alarm was switched off and they were trapped behind security bars and a door screwed shut. Sympathy for them and their families could easily combine with outrage at the circumstances of their deaths and prompt an urge to punish someone other than just the arsonist, most obviously the operators of the hostel. That urge must be resisted unless a careful examination of the law and the facts demonstrates that charges are warranted. I shall attempt to undertake such an examination.

7.1 Manslaughter

Section 291 of the Criminal Code provides that it is unlawful to kill another person unless that killing is authorized, justified or excused by law.

Section 293 provides that any person who causes the death of another is deemed to have killed that person.

Section 300 *Criminal Code* states that "*any person who unlawfully kills another person is guilty of a crime, which is called murder, or manslaughter, according to the circumstances of the case."*

Insofar as is relevant to this case, s302 defines murder as an unlawful killing where the offender intends to kill or do grievous bodily harm.

[9] see *Short v Davey* [1980]Qd R 412

Section 303 provides that any person who unlawfully kills another in circumstances which do not constitute murder is guilty of manslaughter.

There is no evidence indicating that either Mr Atkinson or Mr Dobe intended any harm to come to the guests in their hostel. The offence of murder does not therefore arise for consideration.

It might be thought that there is an absence of evidence to prove a sufficient causal link between the actions of the hostel operators and the deaths of their guests in view of the fact that the operators were asleep at the time Mr Long started the fire and did nothing to support or encourage his fiendish arson. However, in some circumstances, the provisions of the Criminal Code impose special duties of care on people, the breach of which can provide that link if criminal negligence can be established.

Section 289 is one such section. It provides that:

> "*It is the duty of every person who has in the persons charge or under the person's control anything… of such a nature that, in the absence of care or precaution in its use or management, the life, the safety or health, of any person may be endangered, to use reasonable care and take reasonable precautions to avoid such danger, and the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to perform that duty."*

To succeed, a prosecution under this section would require proof that:-

- Messrs Atkinson and Dobe had the hotel under their charge of control;
- the hostel was, in the absence of care or precaution in its use or control, a dangerous thing;
- they failed to use reasonable care or take reasonable precautions to avert the danger the hostel presented; and
- as a result of that failure the deaths occurred.

The operators clearly had the hostel under their charge and control in the requisite sense. They determined the occupancy arrangements and they had control over the safety equipment. It could be argued that it was their responsibility to make the hostel safe, or close it.

The next issue is whether the hostel could be held to be a potentially dangerous thing within the terms of the section. Having regard to its state on 23 June 2000, I consider this could be the case. The factors I consider relevant are:-

- there were 88 people sleeping in the premises;
- the fire alarm was known to be inoperable;

- some of the exit doors in the accommodation areas were blocked by furniture and fixed closed and there were security bars on some windows; and
- in the event of a fire, unless the occupants could quickly exit the building there was a real possibility that those who did not could die.

I consider a jury could well characterize such premises as being something that, in the absence of care or precaution in its use or management, the life, safety or health of the guests may be endangered and indeed their counsel conceded as much.

The next question is whether reasonable care or precautions were taken by Messrs Atkinson and Dobe to avoid such danger. This is really the heart of the criminal negligence or involuntary manslaughter provisions and it is the aspect that creates the greatest difficulty.

On their face, the words of s289 are redolent of civil negligence – *reasonable care, breach of duty* - but the courts have consistently, and understandably, held that to be criminally liable the prosecution needs to prove a more blameworthy departure from the expected standards than is required by a plaintiff seeking civil redress. The classic judicial articulation of this difference is found in *R v Bateman* [10] where Hewart LCJ said:-

> *In explaining to juries the test which they should apply to determine whether the negligence in the particular case amounted or did not amount to a crime, judges have used many epithets, such as "culpable", "criminal", "gross", "wicked", "clear", "complete". But, whatever epithet be used, and whether an epithet be used or not, in order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and* ***showed such disregard for the life and safety of others as to amount to a crime against the State*** *and conduct deserving punishment … It is desirable that, as far as possible, the explanation of criminal negligence to a jury should not be a mere question of epithets. It is in a sense a question of degree and it is for the jury to draw the line, but there is a difference in kind between the negligence which gives a right to compensation and the negligence which is a crime. (emphasis added)*

In a useful analysis of the relevant principles, Professor Yeo and Ms Callahan[11] suggest that it is the different functions served by the criminal law as distinct from the civil law that have resulted in the courts requiring quite different degrees of negligence before a breach of the former can be proven. Those authors contend that in civil cases, any falling below the standard reasonably expected will found liability if it can be shown to be sufficiently

[10] *R v Bateman* (1925) 94 LJKB 791; [1925] All ER Rep 45; (1925) 19 Cr App R 8
[11] Callahan R, Yeo S, *Negligence in medical manslaughter cases,*(1999) 6 Journal of law and medicine, 253

connected with the harm sued for. In criminal cases however, the amount and degree of negligence determine whether a crime can be made out.[12]

However, the challenge remains identifying that degree. Indeed it was suggested as long ago as 1866 that criminal negligence is impossible to define and the distinction between civil and criminal negligence can only be gauged by looking at actual judicial examples.[13]

In *Taktak' case,*[14] Yeldham J examined some of the common law criminal negligence cases concerning a duty to provide medical assistance. When considering whether negligence is sufficiently serious to amount to criminal negligence, His Honor quoted passages indicating that "*a very high degree of negligence*" is necessary, and "*indifference to an obvious risk*". Citing a passage from *Stone*[15]*,* His Honor indicated that the prosecution had to convince the jury that the defendant had a reckless disregard to the danger and that mere inadvertence would not be enough.

Another useful examination of the authorities and a formula or test for criminal negligence is contained in *Nydam v The Queen*[16]*,* a Victorian case which has recently been affirmed by the High Court in *R v Lavendar*.[17] In *Nydam*, the court said that to amount to criminal negligence the act causing death must have involved such a great falling short of the standard of care which a reasonable person would have exercised in the circumstances and which involved such a high risk of serious harm that the act merited punishment. Unfortunately the decision gives little guidance on how the magnitude of the lack of care is to be gauged. With all due respect to their Honors, it may also be thought to be somewhat circular to suggest conduct amounts to a crime if it deserves a criminal sanction.

Applying those principles to the facts of this case I consider the following factors support an assertion that the operators failed to take reasonable precautions:-

- the alarm system was turned off two or three weeks before the fire;
- there was no attempt to replace that system with a temporary one such as a series of battery powered smoke detectors of the kind employed by a previous operator;
- no attempt was made to clear the obstructed doorway in room 7 leaving only one exit that was not useable in the circumstances that unfolded on the night in question; and
- according to the objective standards there were more people accommodated in room 7 than was safe.

There are however aspects of those same factors which weigh against them constituting criminal negligence, namely:-

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[12] ib id p257
[13] R v Noakes (1866) 4 F & F 921 quoted by Callahan *et al, ib id,* at 258
[14] (1988) 34 A Crim R 334
[15] [1977] QB 354 at 481
[16] [1997] VR 430
[17] [2005] HCA 37

- The evidence indicates an absence of any statutory requirement that a fire alarm system be installed.[18] It would be incongruous if by turning the malfunctioning system off, the operators were placed in a worse position so far as the criminal law is concerned than if they had no system installed.

- There is ample evidence that the operators took considerable action to try and remedy the defects in the alarm system. It isn't the case that they simply turned the system off and ignored it. The last approach to an electrician for assistance with the problem was made only three weeks before the fire and at about the same time they obtained a quote to upgrade the alarm system.

- While it seems the blocked doorway in room 7 constituted a breach of the Building Fire Safety Regulation 1991, a number of fire service employees saw the room in this condition and raised no concerns. Indeed, even at the time of the inquest there was disagreement among some of those witnesses as to whether it posed an unacceptable danger.

- Further, after turning off the alarm system, the operators continued to reside in the premises themselves, presumably because neither foresaw the danger occasioned by turning the alarm system off. It may be argued that as the test for reasonableness is objective, what the operators thought is not relevant if a reasonable person would have considered that the hostel was in an unacceptably dangerous condition. However, it is support for the contention that the operators did not show an indifference to an obvious risk or a reckless disregard to the danger. There is no evidence that the operators were cognizant of the danger and failed to take any action out of a callous disregard for the safety of others.

In my view, while it would have been far preferable had the operators had in place an adequate fire warning system and had removed the obstructions from the escape routes, I do not consider a jury could reasonably find that the conduct of the operators were so derelict as to amount to criminal negligence.

Further there are other difficulties in proving an offence under s289. I mentioned earlier that the criminal negligence provisions can obviate the need to prove causation but that is only to the extent that it doesn't have to be shown that an accused directly caused the death. It is still necessary for the Crown to prove that the death occurred as a result of the failure to take reasonable precautions, or as is said in s289 *by reason of any omission to perform that duty."*

Of relevance in this context is the fact that the fire was deliberately lit and progressed with amazing speed throughout the building. The fire was not caused or contributed to the negligence of Messrs Atkinson and Dobe.

[18] Statement of Corser para.31

So, even were the failings I have referred to sufficient to amount to criminal negligence the Crown would also need to prove that but for those failings the deaths would not have occurred. I do not consider they could do that. Obviously, were the alarm turned on there is more chance that it would have activated and warned the guests of the need to flee and were both doors to room 7 operational there is more chance that the people in that room could have fled to safety over the front verandah, but that is far from sufficiently certain to enable the Crown to discharge its onus. For example two of the guests in adjacent rooms died even though they had access to the passage that was blocked to the occupants of room 7. I therefore conclude that Messrs Atkinson and Dobe should not be committed on a charge relying on s289.

The other provision which requires consideration is section 290. It says:-

> *When a person undertakes to do any act the omission to do which is or may be dangerous to human life or health, it is the person's duty to do that act, and the person is held to have caused any consequences which result to the life of health of any person by reason of any omission to perform that duty.*

It could be argued that when operating the hostel Messrs Atkinson and Dobe had undertaken to do it in accordance with the duties imposed on them by the Building Fire Safety Regulation 1991 which were summarized in the "*Duties of owner/occupier*". One of these was an obligation to maintain adequate means of escape free of obstruction. It could be argued that the blocking of the doorway in room 7 was in contravention of this duty. However, in my view this prosecution would also fail because it could not be shown absent this obstruction the people in room 7 would necessarily have survived.

I therefore find that no person should be committed to stand trial in connection with the deaths.

8. Recommendations – Riders

8.1 Introduction

Pursuant to s43(5) of the Act I am authorised to make riders or recommendations designed to reduce the likelihood of the recurrence of similar deaths to those investigated by this inquest. In order to do that it is necessary to identify the factors which allowed a potentially dangerous situation to exist. Broadly speaking, that requires an analysis of the regulatory regime which governed fire safety in budget accommodation in 2000 and an assessment of whether the individuals or agencies with responsibility under that regime adequately discharged them. I will then be in a position to consider whether the changes made since the fire are likely to address the systemic causal factors.

Before going into detail about those matters, some general observations may be helpful. Although this type of analysis naturally focuses on what went wrong and therefore can reflect adversely on those involved, it is important to note that apart from the action of Mr Long there is no evidence that any of the failings which contributed to this disaster were deliberate or malicious. In hindsight, the performance of individuals may seem suboptimal but it is appropriate to acknowledge three mitigating factors. First, the actions of those with regulatory responsibility occurred in a context that is now universally recognised to be unclear and administratively untidy. Second, although fire has long been a prevalent killer, it was not in 2000 regarded as a particularly portentous hazard for hostels and none of the prevention strategies foresaw the danger of arson. And third, although some of the factors that contributed to the fatalities were avoidable, none of the failures or mistakes by themselves caused the disaster.

In his ground breaking work on root cause analysis, Professor James Reason postulated that catastrophic outcomes usually only occur when numerous barriers fail and the opportunity for a serious mishap presents because, co-incidentally the gaps in safety systems combine or coincide.[19] Graphically, he uses the analogy of a stack of slices of Swiss cheese. Only when the holes in the cheese slices align, do errors that are by themselves minor, allow a single final causative action to go through all the preventive layers and result in serious consequences. The deaths in the Palace Backpackers Hostel fire were, in my view, only preventable in this sense. They resulted from numerous mistakes all falling the same way. It is important to accept that it is systems failures that contribute to such outcomes rather than the actions of individuals. It is wrong to scapegoat any individual by focussing on one of the mistakes, when, without numerous other failings, none by itself would have caused the fatal outcome.

For example, in this case the fatalities could be traced back as far as the decision to place a roof over the space between the two blocks of the hotel creating a chimney like effect that so dramatically fanned the flames of the fire 40 or 50 years later. Then there was the failure of the council to adequately consider the impact of the change of use of the building from an antique shop or single residence to a hostel accommodating far more guests that ever would have been the case when, in years gone by, it operated as a hotel. Even when it introduced a local law dealing with occupancy levels in 1996 it waited another three years before making them operable and then failed to enforce them. There was also the substandard installation of the fire alarm, the poor maintenance of it and the failure of the expert repairers to rectify the faults when the equipment was twice sent to them. Along the way the council again failed to give due regard to the implications for fire safety when the operators converted a bathroom to a crowded dormitory and blocked off one of its doors and removed the fire sensor from the television lounge room. None of the firefighters who went to the building ever tested the alarms.

[19] Reason JT, *Understanding adverse events: human factors*, In, Vincent C.A.,ed., *Clinical risk management*, London BMJ 1995

This is an overview of how the dangerous condition of the hostel came to exist in June 2000. I shall now give the detail of the regulatory regime and the performance of the regulators as foreshadowed.

8.2 Regulatory regime governing fire safety in hostels as at 2000

In 1993, when Mr Hartnett assessed Mr Moore's application to convert the Palace Hotel building into a backpackers hostel, he reviewed the relevant Building Codes and Council by-laws and formed the opinion that there was no need to alter the classification of the building. This was based on his assessment that as the building had been constructed and operated as a hotel unlit 1988, it was already a class 3 under the provisions of the Building Code of Australia which referred to "a boarding house, guest house, hostel, lodging house or backpackers accommodation."

A change of classification should occur when the purpose for which the building is designed, constructed, or adapted to be used is changed such that the change would alter the classification of the building under the Building Code of Australia. This includes a change in the nature or quantity of materials stored, displayed, or utilized in a building in excess of restrictions or use or occupation of the building imposed on a certificate of classification. The standard building regulation prohibits the change of classification occurring unless the building complies with this regulation for the new classification and the owner has obtained approval for the change of classification.

Because the use of the premises as a backpackers hostel did not, according to Council, require an alteration of the building's classification, there was no statutory requirement to install and maintain a fire alarm system.

When no application to alter the classification was required, there was then no regulatory framework that adequately addressed issues of fire safety because there was in those circumstances no obligation to refer the question of fire safety for the consideration of the QFRA (as it then was).

As at 1 January 1992, the *Fire and Rescue Authority Act 1990*, part 9A "Building Fire Safety" required occupiers of existing buildings to maintain:-

- means of escape from a building;
- the prescribed fire safety installations; and
- a fire and evacuation plan."

A "prescribed fire safety installation" is defined in s.104D of the *Fire and Rescue Authority Act 1990* to mean equipment that was at any time required to be maintained in the building in question by or under any act, including as a pre-requisite to the granting of any approval or the issue of any notice, certificate or instrument. In this case because there was no provision mandating the installation of a fire alarm it did not become a prescribed fire safety installation and therefore there was no obligation placed on anyone to test it or maintain it.

It is apparent that the legislative framework regulating fire safety left a significant gap between existing buildings where no change of classification was required or building work carried out and new buildings which were covered by an extensive and adequate fire safety regulatory scheme.

Subsequent to the initial approval the ground floor toilet and shower room in the atrium area was fitted with a loft double bed and the first floor bathroom was converted into a 10 bed dormitory.

These alterations potentially increased the fire load and occupancy levels so as to impact on the safety of persons accommodated on the premises. However, no building approval was sought and those who gave evidence at the inquest continued to maintain that none was required. If one had been completed then there may well have been a change of classification of the premises for the reasons advanced above. This in turn would have required an assessment of the fire safety requirements and indeed the prescribing of fire safety installations which in turn would have then required ongoing routine maintenance and the keeping of records of such maintenance. Alternatively, a building application could have prompted the Council to take action under The *Standard Building By-Laws 1991* which in s.1.5(3) provide: -

> "the Local Authority may require that a part of the building or other structure or the entire building or other structure be brought into conformity with these by-laws or parts of these by-laws or as though it were a new building or other structure if –
>
> (a) …
>
> (b) … the local authority considers that the safety of persons accommodated in or using the building or other structure, or the risk of the spread of fire to adjoining buildings or other structures, warrants it.

The net effect of the legislative requirements as they existed when the building was converted to a backpacker's hostel and largely up until the fire was that there was significant uncertainty as to what was, in fact, required by way of fire safety.

8.3 Regulatory agencies discharge of their responsibilities

8.3.1 The Isis Shire Council

Any criticism of the failure of the Isis Shire Council to adequately regulate the safety of the hostel has to be seen in the context of the prevailing legislation which allowed premises such as the Palace Backpackers Hostel to operate without a proper regulatory framework governing fire safety issues.

Mr Hartnett, the building surveyor, did recommend the installation of various fire safety devices including the alarm system although he recognized that he had no power to enforce such recommendations. Those items were in fact installed and so far as Mr Hartnett was aware were operating correctly.

It is concerning, however, that although Mr Moore advised the Council of his intentions for the building no formal consideration of the need for its reclassification was undertaken by the Council and no proper assessment seems to have been made of the appropriate occupancy levels. Even when significant changes were made to the use of rooms in the hostel that could obviously effect fire safety, little or no formality or precision was evident in the Council's response. All changes seem to have proceeded with a few telephone calls, a few un-minuted meetings and minimal documentation of reasons or decisions.

The Council is unable to explain the process by which Mr Moore was apparently advised that he could accommodate up to 90 people in the hostel and took no action to enforce the local law it passed in 1996 which prescribed conditions that should have prohibited more than 53 people from staying in the hostel. There is no evidence that over crowding contributed to people not being able to escape the fire. Obviously, however, had there been fewer people in the hostel, particularly room 7, it is foreseeable that fewer would have died.

The Council seems to have failed to appreciate that the alteration of the premises and the resultant increased fire load may have compromised occupants' safety. Mr Hartnett only made two inspections of the premises and seems to have been very casual in his consideration of the impact of converting the upstairs bathroom into a dormitory.

However, in its defense, the relevant council officers did consult the appropriate QFRS officer in 1993 and his recommendations were followed. The Council considered that it had no power to mandate adherence to the recommendations, nor audit compliance; consequently this was not done.

Despite this level of laxness, there is nothing to indicate that the Council was aware, or should have been aware that the hostel posed a fire safety risk to its occupants.

8.3.2 The Queensland Fire and Rescue Authority

The evidence establishes that when the Council building surveyor was contacted about the change of use of the Palace Hotel building he recognized that expert fire safety advice was necessary and he arranged for the involvement of the appropriate QFRS officer, Mr Lawgall, to inspect the premises.

Mr Lawgall gave appropriate advice as to fire safety equipment but seems to have merely accepted Mr Harnett's view that no formal referral to the QFRS was necessary. Once again this highlights the absence of any sufficiently stringent regulatory requirements if the local council considers the classification of the building had not changed.

It is concerning that Mr Lawgall seems not to have appropriately documented his involvement in the assessment of the fire safety needs of the hostel but it cannot be shown that had he done so any other action would have been taken.

The only other presence on the premises of fire officers was by volunteer fire fighters who often conducted training sessions at the premises to familiarize themselves with it's layout in case of a fire. They had no training or responsibility to undertake adequate fire safety inspections that may have identified the problems that have become apparent since the fire.

In these circumstances it is difficult to be critical of anyone connected with the QFRA.

8.4 Task force recommendations and implementation

Immediately after the fire the Minister for Emergency Services established a Building Fire Safety Taskforce comprised of high level representatives from all relevant government departments. Naturally, senior officers from the QFRA held key positions on the steering committee and the taskforce.

The taskforce was directed to investigate and report on fire safety in all budget accommodation in Queensland. It was to consider legislation and the resources dedicated to administering and enforcing fire safety. In the process, it had access to all of the various expert reports that have been tendered at this inquiry and it consulted extensively. Information gleaned from inspections of over 1500 such facilities informed the deliberations of the taskforce.

The taskforce came to the same conclusions as this inquest, namely that uncertainty about responsibility for some aspects of fire safety monitoring and the level of safety compliance to some extent depending upon when the building was constructed or what previous uses had been made of it was compromising fire safety.

In response, the key recommendation of the taskforce was that there be set a minimum standard of building fire safety that was to apply to all existing budget accommodation, irrespective of when the building was constructed. That standard would be that required of new buildings by the Building Code of Australia. It is to be supported by a system of testing, maintenance and auditing designed to ensure compliance.

The *Fire Safety Standard* commenced on 1 July 2002 and it applies to all building used to accommodate six or more occupants who share facilities. The Budget Accommodation Project is devoted to monitoring and reporting on compliance with the standard.

The Joint Inspection Program (state and local government compliance inspection program) completed first stage inspections by 30 June 2006 except for a small number of buildings in cyclone affected areas.

A grant and loan scheme has been put in place to assist owners to pay for compliance work.

A bill to amend the *Fire and Rescue Service Act 1990* is now before parliament.

A review of the *Building Fire Safety Regulation 1991* is currently underway.

The *Fire Safety Standard* has also been amended to provide owners with additional compliance options and to clarify application and compliance issues. Compliance can be by way of performance criteria that address issues such as early warning, emergency lighting, occupant density, exit travel, smoke management etc. Operators are required to have a fire management plan and are obliged to ensure that the new fire safety standards and building features are maintained.

An important policy consideration for the Budget Accommodation Project was that fire safety should be improved while minimising closures to avoid contributing to homelessness. Compromises have been necessary. For example, recommendation 11 of the Taskforce Report concerned the fire retardants in furnishing. It has been found that there is currently no easily applicable standard to apply or vehicle to carry the recommendation forward.

Evidence was given to the inquest that as at 31 May 2006, 71.2% of buildings to which the *Fire Safety Standard* relate are fully compliant and 19.9% are substantially compliant. Approximately 9% of buildings still have major work to do including 7.6% which have high risk issues.

Of course all that I have recited in this section comes from the statements, reports and oral evidence given to the inquest by officers from the Department of Local Government, Planning, Sport and Recreation and the Queensland Fire and Rescue Service. In the time available to me, I have not been able to independently verify what they have told me, nor even subject it to searching scrutiny but I have no reason to doubt the veracity of their information. It is apparent that since the fire there has been a very high level of commitment and activity across numerous State Government departments and local authorities that has seen a metamorphosis in building fire safety.

However, there is always a risk that as the horror of the Palace Backpackers Hostel fire fades from the public consciousness, and new priorities demand the commitment of extra financial and human resources, these reforms will be allowed to degrade. I know the professional and volunteer fire fighters of this State who risk their lives when fires occur would prefer sufficient resources continue to be devoted to prevention. It is incumbent on their superiors and the Sate Government to continue to provide the leadership and the resources to enable that to happen.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
7 July 2006.