National Coroners Information System (NCIS)
Bulletin

May 2007

House Fires

This publication outlines some trends and patterns extracted from the NCIS database where an individual has died as a result of a residential fire. Basic demographic details and the types of deaths associated with residential fires are examined. The publication also highlights coronial recommendations made and provides links to sources of additional information.
NCIS has previously compiled reports re house fires and the presence of drugs / alcohol
In the deceased. Please contact NCIS for further information of these reports.

WHY FOCUS ON HOUSE FIRES?

From 2001 to 2006, there were 458 deaths due to house fires. Approaching winter, a review of the frequency and preventative recommendations made surrounding house fires is timely.

State	2001	2002	2003	2004	2005	2006	Total
ACT	2		5		1	1	9
NSW	22	39	36	33	28	11	169
NT	-	2	2	1	1	-	6
QLD	11	19	14	9	8	-	61
SA	11	9	10	7	4	8	49
TAS	2	6	7	9	3	1	28
VIC	15	28	21	19	23	2	108
WA	7	7	7	2	4	1	28
Total	**71**	**110**	**102**	**80**	**72**	**24**	**458**

INTENT— The role of human intent in the occurrence of injury

Intent Completion	Total
Unintentional	312
Intentional Self-Harm	84
Unlikely to be known	28
Interpersonal Violence	23
Natural Deaths	11
Total	**458**

NCIS

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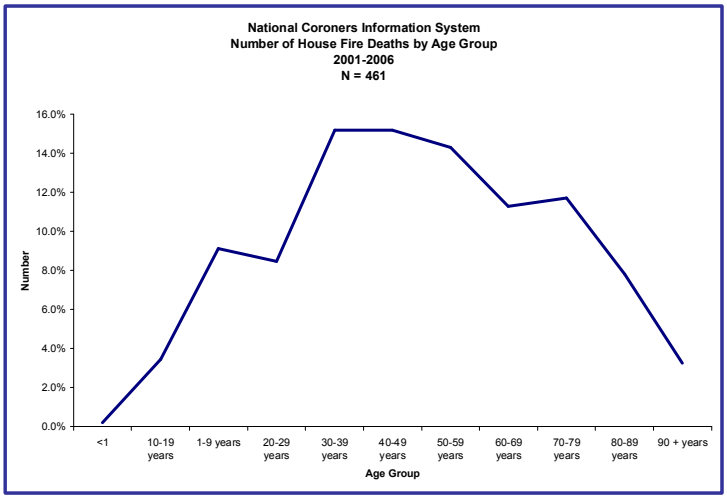
Case Statistics for Residential Fire related Deaths between 2001—2006

Number of by House Fire Deaths by Age

<1 Year	1
1-9 Years	42
10-19 years	16
20-29 years	39
30-39 years	70
40-49 years	69
50-59 years	65
60-69 years	52
70-79 years	54
80-89 years	35
90 + years	15
Grand Total	458



Number of House Fire Deaths by Gender

Female	166
Male	292
Grand Total	**458**

Number of House Fire Deaths by Activity

Activity Code	Total
Resting, Sleeping	141
Self inflicted harm	84
Unlikely to be known	68
Unspecified personal activity	34
Other Specified activity excluding travel	33
Cleaning cooking clothes washing etc	26
Other specified personal activity	15
Other specified leisure activity	9
Unspecified leisure activity	9
Eating Drinking	6

The majority of incidents occurred when the deceased was resting/sleeping (31%). The second most common activity when involved with a 'house fire' is self inflicted harm (19%)

Case Statistics for Residential Fire related Deaths

Number of deaths by Incident Location—The most commons locations are:

Location of Incident	Total
Free-standing house	308
Flat, apartment, terrace house	92
Caravan, mobile home (residential)	19
Farm-house	15

NCIS Data

The percentage of cases open may impact the number of cases identified in our findings. The average case closure rates for NCIS are shown below.

State	% Closed
ACT	88%
NSW	73%
NT	88%
QLD	70%
SA	94%
TAS	90%
VIC	88%
WA	71%
Average	**83%**

Employment Status	Total
Retired/Pensioner	174
Employed	97
Unlikely to be Known	56
Unemployed	52
Child Not at School	35
Student	27
Home Duties	15
Other	2
Total	**458**

Further Reading

Elder, A T. Squires, T Buscttil, A. **Fire fatalities in elderly people** Age & Ageing. 25 (3): 214-6, 1996 May

Squires, T Buscttil, A. **Can child fatalities in house fires be prevented?** Injury Prevention. 2(2): 109 13, 1996 June

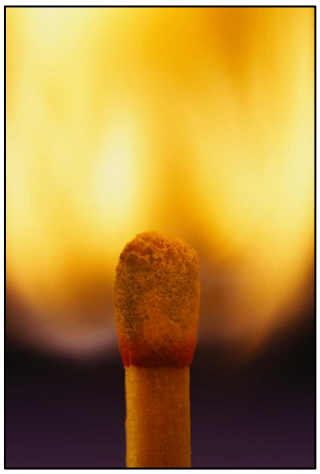
Barillo, D J. Goode, R. **Fire fatality study: demographics of fire victims.** Burns. 22(2): 85-8, 1996 Mar.

House Fire Related Deaths by Object

Table—House Fire Related Deaths by Object:

The most common objects (coded variable) involved in a house fire death were:

* Fire Flame Smoke,
* Personal Use Item,
* (Household) Appliance,
* Miscellaneous Object Substance, and
* Chemical Substance Non-Pharmaceutical

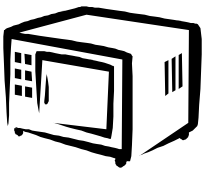


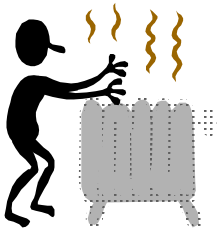
The most common 'object' coded for house fires was ; **Fire Flame Smoke.** The items below provide further detail what Fire, flame and smoke includes.

Fire, Flame, Smoke	Number
Uncontrolled fire in building or structure	349
Ignition of highly flammable material	104
Other specified smoke fire and flames	20
Uncontrolled fire not in building or structure	15
Controlled fire in building or structure	13
Ignition or melting of other clothing and apparel	12
Ignition or melting of nightwear	12
Controlled fire not in building or structure	3

The second most frequently documented 'object' coded for house fires was ; **Personal Use Item.** The items below provide further detail of Personal Use Items:

Personal Use Item	Total
Tobacco/tobacco products	45
Cigarette Lighter	28
Match	8
Possibly Match/s or Cigarette Lighter	3
Self Immolation with petrol and match	3
Other	9





Household appliances were the third most frequent objects involved in house fires.

(Household) Appliance	Total
Cooking appliance	26
Heating appliance nec	15
Radiator	15
Unspecified appliance	3
Electric Blanket	2
Possibly Power Board or Electric Blanket	2
Television Set	2
Other	6

* Based on where the 'Recommendation/Warning' field is recorded by coronial staff as 'Recommendations Made/warnings Made'.

ISSUE: DEAD LOCKS

CAUSE OF FIRE: MATCHES/CIGARETTE LIGHTERS OR INCENSE CANDLES

TAS 2006.98

The deceased, aged 43 years, died as a result of the combined effects of smoke inhalation due to a house fire and acute alcohol intoxication.
After extinguishing the fire Tasmania Fire Service personnel located the body of the deceased in the rear of the premises in the laundry area, at the bottom of the back door. The rear door was found to be dead locked with no key evident in the lock; personnel were unable to determine if the front door was likewise locked due to the damage in that area. Fire Investigator's revealed the fire started in an area within a two metre radius of an armchair in the lounge of the unit. A next door neighbour was spoken to and it was established the deceased had a habit of sitting in the chair reading books and doing puzzles. He was a smoker and heavy drinker. The deceased did not like the smell of cigarette smoke and would burn incense candles to cover the smell.

The Fire Investigator 's made the following comments as to cause;
'...taking into consideration the eye witness statements, the statements from the responding fire crew and the physical evidence I can conclusively say the fire has started in the area of the lounge room within an approximant radius of two metres of the arm chair.

After concluding the investigation there are two possible scenarios for the cause of this fire;

The first being that the deceased had been in his arm chair reading and smoking and has fallen asleep and dropped his cigarette on the arm chair or on to the floor close to the chair. Fine combustible materials such as paper on the floor has ignited and started the fire.

The second scenario was that again the deceased was in his arm chair and he has had an incense candle burning and accidentally knocked it over and caused the fire to start....'

Due to the lack of evidence to support either possible scenario I can not conclusively say which one was the cause of the fire. I can say the fire appears to have started accidentally'

A Forensic Scientist has also stated *'... The blood alcohol concentration identified approaches the potential fatal range when alcohol has been consumed alone. Combined with the centrally acting diazepam and carbon monoxide levels above normal range would cause significant central nervous system depression and probable death.'*

COMMENTS & RECOMMENDATIONS :

I feel it necessary to comment on the dangers of dead locks and echo the strong recommendations of the Tasmania Fire Service that people who have dead locks fitted to doors have the keys in the locks at all times while at home to ensure a safe exit of the house in the case of an emergency.

Planning an evacuation....Preparation

* ....Deadlocked doors can block your escape route
* When at home, leave keys in any deadlocks or on a hook (perhaps attached to a chain) near the door....
* If there are bedrooms upstairs, store a strong rope ladder there to provide an alternate escape route...

Department of Health and Human Services. Our Kids Bureau Housing Tasmania, **Fire Safety at Home**
http://www.fire.tas.gov.au/mysite/publications/commsafetyA416=6.pdf
Accessed 08/05/2007

ISSUE: ELECTRICAL PRODUCTS

CAUSE OF FIRE: ELECTRIC BLANKET

TAS 2004.612

The deceased, aged 73 years, died as a result of thermal injuries suffered in a house fire.
In the early morning the Tasmanian Fire Service in Launceston was notified of a fire at the deceased's residence. Fire units arrived at this residence and observed that the house fire was well established. The burnt remains of a male person were located in the area in which the front bedroom of the house had been located.
A number of persons who knew the deceased advised that it was his usual practice to leave his electric blanket on all day long on a high setting. Two separate findings most probably explain the chain of events leading to the cause of the fire and the death of the deceased.

1. In respect of the bed located in this bedroom, the area of most fire damage was identified to be the bottom right hand corner of that bed.
2. In the shower cubicle of the ensuite attached to that bedroom there were the remains of a double bed electric blanket. No other evidence as to the existence of an electric blanket on the double bed was identified.

Given the confirmed practice of the deceased to leave his electric blanket on a high setting all day, the fire examiner suggests that this practice initiated some form of combustion of the deceased's bed. It is reasonable to presume that at some stage during his attempts to deal with this situation he has, either as a result of smoke inhalation or some other reason, collapsed and then become engulfed in the fire.
This tragic outcome sadly serves to once again to illustrate the dangers of using electric blankets other than whilst they are in a serviceable condition and in accordance with the manufacturer's recommendations.

Additionally, the Coroner noted the following recommendations made by the Tasmania Fire Service:

"Electric blankets

* *Leave electric blankets on the bed all year round – or roll them up for storage as folding them may cause damage to the wiring.*
* *Make sure your electric blanket is laid flat and tied firmly to the bed.*
* *Always switch the blanket off before going to bed or leaving the house.*
* *Sleeping with your electric blanket on is dangerous. Your body weight may cause the blanket to over-heat, damaging the wiring and starting a fire.*
* *Placing heavy objects on your electric blanket can cause spot heating or damage the wiring and start a fire.*
* *Run your hand over the blanket regularly. If you suspect spot overheating, turn it off and have the blanket checked by an authorised repairer or replace it."*

* ....Faulty or overloaded electrical circuits may heat up enough to cause a fire...
* Never run cords under carpets, rugs or furniture because they can overheat and cause a fire....
* If an electrical appliance catches fire, switch it off at the power pint if safe to do so, or at the fuse box.....If it keeps burning, leave the house and call '000'for help...

Department of Health and Human Services. Our Kids Bureau Housing Tasmania, **Fire Safety at Home**
http://www.fire.tas.gov.au/mysite/publications/commsafetyA416=6.pdf
Accessed 08/05/2007

ISSUE: ELECTRICAL PRODUCTS

CAUSE OF FIRE: ELECTRICAL FAULT—MOTORISED SCOOTER

VIC 2004. 2426

The deceased, an 80 year old gentleman, resided in a bungalow at the rear of his sisters and brother in laws residence. The deceased had limited mobility and used an electric scooter for transport and move around the bungalow.
On the evening in question, the deceased sister cooked dinner for him and assisted him to bed, as was her usual practice.
The next morning, the deceased brother in law noticed smoke emitting from the bungalow. He was unable to enter the bungalow due to the amount of smoke. The gentleman was deceased when emergency personnel attended.
The scene was examined and the point of origin of the fire was determined to be the scooter due to burn patterns on the scooter and the bed. The charging lead was still plugged in, and there appeared to be an arc bead on the charger line, indicating that the power was on at the time of the fire. The fire was confined to the electrical scooter and the top end of the bed and the two walls in the corner above the mattress. There were no fire alarms or smoke detectors fitted inside the bungalow.
It is believed the fire that lead to the death was caused as a result of the way the deceased attached the power supply cord to the scooter by leaving it connected to the power cord receptacle and draping the cord over and around the seat, thereby crushing or pinching the cord. This was contrary to the manufacturers recommendations.

"RECOMMENDATIONS:
It is clear that the manufacturers of the scooter have turned their mind to avoiding such accidents in the future. I would recommend to the Therapeutic Goods Administration and the Victorian Office of the Chief Electrical Inspector together with the manufacturer that they continue on the path already started in determining and adequate warning notice that could be placed on such scooters bearing in mind that the users are often frail and the elderly.....
In addition, the authorities may during their deliberations into preventative messages concerning this scooter turning their minds to any electrical products that the frail and elderly may use, such as the flagging notice that is attached to hair dryers."

ISSUE: FLAMMABILITY OF CLOTHING

CAUSE OF FIRE: COOKING

VIC 2004.2509

* **....Cooking fires are one of the most common causes of house fires in Tasmania...**

Department of Health and Human Services. Our Kids Bureau Housing Tasmania, **Fire Safety at Home**
http://www.fire.tas.gov.au/mysite/publications/commsafetyA416=6.pdf Accessed 08/05/2007

The deceased, aged 83 years, lived at the rear of her daughters house in a self contained granny flat. The cause of death was burns.

The deceased daughter has found her mother on the lawn between the granny flat and the house badly burnt. The deceased had removed her clothing in an attempt to extinguish the flames. CFA members entered the granny flat to ensure no fire was present. The deceased son-in-law had previously entered the unit and found a burning saucepan on the stove, which he removed and turned off all elements on the stove.
It is believed that the deceased was cooking on her stove and the sleeve of her dressing gown caught fire. The scattered burnt clothing in the yard indicated that the deceased had dropped to the ground in an effort to extinguish herself.

RECOMMENDATIONS:

1. That the Fire Service agencies, Office of Gas Safety and Consumer Affairs Victoria review the standards for flammability warning labels on adult clothing.
2. That the Fire Service agencies, Office of Gas Safety and Consumer Affairs Victoria review the issue of public warnings via a variety of agencies such as Senior Citizen organisations, gas distribution companies, insurance companies etc.

ISSUE: ISOLATION OF ELECTRICITY

CAUSE OF FIRE: NOT STATED

NT 2002. 204

A next door neighbour noticed the deceased's house was on fire and called the Vice Captain of the Fire Emergency Rescue Group (FERG). Other members of the FERG arrived, noting the house was fully alight with flames coming out the windows, and as the electrical supply was still connected and it would be too dangerous to put water on the residence. One FERG member stated that it took Northern Territory Power and Water (PAWA) approximately 35-40 minutes to attend and disconnect the electricity. Police attended the scene. After the power supply was switched off and the house fire was extinguished, police investigated the scene and found the deceased lying in the doorway of the bedroom.

The coroner stated: "The cause of death was unintentional being burns resulting from a house fire."

RECOMMENDATION

That the Fire Service ensures that Fire Emergency Rescue Group (FERG) units are made aware that PAWA can isolate the electricity to specific areas, and supply and provide training in the use of fuse sticks so local FERG members can isolate the electricity supply.

ISSUE: CHILDREN AND MATCHES/LIGHTERS

CAUSE OF FIRE: MATCHES/CIGARETTE LIGHTERS

NSW 2004. 5878
NSW 2004. 5880
NSW 2004. 5879

An adult female was asleep in the bedroom area with 2 children. A third child, woke the adult to alert her to a fire in the lounge room or on the lounge. She has entered the lounge room area and seen that the lounge was alight. After trying unsuccessfully to douse flames, she has retreated to the laundry area where she remained until persons have kicked open the back door and she escaped outside. The three children died in the house fire.

The fire is thought to have started by a child playing with a cigarette lighter.

RECOMMENDATIONS

"In the interest of public safety I recommend that the peak Government Departments as well as private organisations involved with children and families promote the following issues in public awareness campaigns:

* Adults must ensure that cigarette lighters are not accessible to children.
* Parents should emphasize to children the potentially lethal human consequences of playing with cigarette lighters.
* In the event of fire, all persons, particularly those in dependent situations such as children should be evacuated from the premises before attempting to combat the fire.
* Occupants of the premises must ensure that all doors and windows can be opened in the event of an emergency.
* Householders should be informed that lounges are made from highly flammable materials and, if set alight, the fire can be expected to develop most rapidly.
* Additionally, I recommend that, in the interest of public safety, the Attorney-General consider, within a specified time period, by the operators of "back to base" alarm systems to owners of premises in the event that the alarm system becomes non-operational."

ISSUE: SMOKE DETECTORS/FIRE ALARMS

CAUSE OF FIRE: NOT STATED

TAS 2003. 424

The deceased was an 82 year old male who died as a result of carbon monoxide poisoning due to smoke inhalation following a house fire.
Neighbours and passers by saw that the deceased's house was on fire, but were unable to enter due to the amount of smoke.
Fire Units attended. Upon their arrival the residence was fully engulfed by flames and took almost an hour to be extinguished. Once the residence was cleared for entry the deceased was located in his bedroom lying on his bed
Fire investigators attended and examined the scene. They were unable to determine a specific cause, but were able to rule out foul play.

RECOMMENDATIONS
From the information before me I am satisfied that there are no suspicious circumstances surrounding this unfortunate death.
Currently the Australian Standards (A.S 3786) that apply to smoke alarms refer only to the smoke alarm sensing unit and not the vibrating pad or flashing strobe unit available. **I recommend** that the installation and maintenance of these additional safety devices be included within A.S 3786 so that a standard is created and met by manufacturers and commercial installers.
I am aware that all accommodation facilities are required to have smoke detectors and alarms installed in each room. Further to this **I recommend** that a system similar to that of the Vibracon be made available to guests who are hearing or visually impaired.
I am recommending that buildings that are leased or rented should be fitted with appropriate smoke alarms at the cost of the owner. They would be, in essence, protecting their own asset as well as providing safety for their tenants. The responsibility for maintaining the alarms would be a matter for the tenant.

CAUSE OF FIRE: MATCHES/CIGARETTE LIGHTERS

NT 2004. 90

The deceased aged 2, resided at a local Aboriginal community. Her primary carer was her maternal aunt.
On the day in question the uncle went to sleep on a bed in the lounge room, and the maternal aunt went to visit neighbours and do some shopping. The deceased elected to stay and play with her puppy and watch television.
After completing her shopping, the maternal aunt went outside the shop and noticed smoke coming from the air conditioner box on the eastern wall of her house.
The uncle was woken by the heat of the fire and saw flames and thick black smoke coming from the mattress that the child had been on. The fire was too big to stay inside. The uncle went outside and along with community members extinguished the fire.
The strongest evidence supports a finding that the fire was accidentally started by the child when she was playing with matches.

RECOMMENDATIONS

"The death was caused by burns received as a result of a house fire. This death was accidental but this is once again a tragic reminder of the disasters that can so easily occur when young, unsupervised children play with fire.
I note that there were no smoke alarms installed in any area of the house.
I **recommend** that the Community Government Council consider seriously their options for improving fire safety in the future. Options to consider could include community education, the instalment of smoke alarms and/or the purchase of appropriate fire fighting equipment."

CAUSE OF FIRE: NOT STATED

QLD 2002. 2705
QLD 2002. 2706
QLD 2002. 2707

The 3 deceased were residents at a Boarding House in Queensland. The building was best described as a 'big Queenslander' made of timber and tin. Witnesses described seeing a small fire underneath the left hand corner of the house. Residents were seen exiting the house as the fire took hold. Three people were not accounted for after the fire.

There were conflicting reports of the presence of smoke alarms. Some residents thought there were battery operated smoke alarms, but did acknowledge that batteries were removed for personal use. The owner of the Guest house stated there was a hard wired system, but it was not connected.

The fire service indicated that the fire was well alight when they arrived, 4 minutes after the call.

RECOMMENDATIONS:

I recommend:

1. Brisbane City Council review its water management practices for replacement of water mains having regard to the capacity of those mains to deliver sufficient volume of water to effectively fight fires.

2. That Brisbane City Council review their systems of monitoring premises to ensure that safety related requirements made by it are complied with within the time stipulated, or, if not, that effective follow up procedures are actually taken.

3. The QLD Fire Service and the Brisbane City Council conduct formal liaison procedures to ensure that they perform their respective fire safety functions in a way so that their effectiveness is maximized and responsibilities of each authority are clearly recognized.

4. That QLD Advocacy Incorporated be involved in any co-regulatory approaches between local government, the fire service and boarding house operators and tenants.

5. Local council authorities and QLD Fire Service review their procedures relating to any element of discretion with council or fire officers in enforcing compliance with safety and fire standards.

6. Review of legislation to consider including dwellings with 6 or less people as also being subject to boarding house licensing provisions.

7. Investigation of possibility of implementation of an automatic cut off system for gas lines in the event of a fire as well as metal enclosures for the meter.

8. Review of legislation to consider empowering an appropriate authority to conduct spot audits of multiple dwellings in relation to safety issues.

9. Review of legislation to elevate fire safety requirements above competing interest of privacy or other tenancy based interest where there is a conflict in relation to multiple occupancy dwellings.

10. Fire protection be reviewed specifically focusing on under floor areas of "Queenslander" style buildings.

11. Review and improve communication methods for fire fighters at the scene of a fire so that they can immediately assess via radio information about water supply or other issues relevant to fire fighting.

12. That appropriate authorities consider commendations for bravery.

13. Electrical and fire safety review of premises at [ ] ....where the evidence indicates there may have been unlicensed electrical work performed.

14. Finally, the most significant preventative measure to ensure fire safety is a hard wired smoke detection system giving early warning of a fire to residents and giving them the opportunity to escape the premises. It is urged that all levels of government and fire authorities concertedly act to ensure the efficacy of these new provisions to avert the repetition of such a tragedy.

Coronial Recommendations Continued...

CAUSE OF FIRE: TOBACCO AND TOBACCO RELATED PRODUCTS

ACT 2003.255

The victim was found deceased at her residential address. The cause of death was smoke inhalation with high carboxyhaemoglobin levels found to be present in her blood. The deceased had been diagnosed with schizophrenia and at the time of her death was subject to an involuntary psychiatric treatment order. The deceased received regular antipsychotic medication by way of intramuscular injection.

The coroner found the cause of the fire was most likely a cigarette igniting a slow smouldering fire on the sofa in the lounge room.

The view of the coroner was that the death was accidental.

RECOMMENDATION

That consideration be given in appropriate circumstances to wiring smoke detectors in premises owned by A.C.T. Government and used for aged care purposes – back to a monitored base if at all feasible.

Further Reading

Douglas, M r. Mallonee, S. Istre, G R. **Comparison of community based smoke detector distribution methods in an urban community.** Injury Prevention. 4(1): 28-32, 1998 Mar.

DiGuiseppi C. Roberts I. Wade A. Sculpher M. Edwards P. Godward C. Pan H. Slater S. **Incidence of fires and related injuries after giving out free smoke alarms: cluster randomised controlled trial.** BMJ. 325(7371): 995 2002 Nov 2

Relevant Links

BushFIRE Arson Bulletin (*An initiative of the Australian Institute of Criminology, the Bushfire CRC and the ACT Department of Justice and Community Safety*)
http://www.aic.gov.au/publications/bfab

NSW FIRE BRIGADE
Smoke alarms
http://www.nswfb.nsw.gov.au/community/athome/smokealarms/

NSW FIRE BRIGADE
May fire safety campaign - Smoke alarm maintenance
http://www.fire.nsw.gov.au/about/news/archive/2007/0501_smoke_alarm_maintance.php

ISSUE: WOOD HEATER

CAUSE OF FIRE: WOOD HEATER

TAS 2004.187
TAS 2004.188
TAS 2004.189
TAS 2004.190

Six children and 2 adults were asleep in the house, when the male adult awoke to find the house full of smoke and noticed an orange glow in the lounge room.

* ....Clothes drying on a clothes horse must be at least 2 metres from the heater (latest recommendation)....
* Put the fire out completely before leaving the house or going to bed (unless it has a good guard)....
* ...If buying a portable heater, buy one that will switch off when knocked over...

Department of Health and Human Services. Our Kids Bureau Housing Tasmania, **Fire Safety at Home** http://www.fire.tas.gov.au/mysite/publications/commsafetyA416=6.pdf Accessed 08/05/2007

The house was fitted with one smoke detector, but neither adult are able to say whether this activated or not. The 2 adults and 3 children managed to leave the house.

Following exit from the dwelling, both adults tried to re-enter the house to get the remaining 3 children, but were unable to due to smoke and heat. Whilst doing so, it appears a male child has re-entered the house.
It took 3 fire units nearly an hour to extinguish the fire and by that stage the majority of the house had been destroyed. The remains of 4 children were located.

Results of the fire investigation conducted by Tasmania Fire Service concluded that the initiation point of the house fire was in close proximity to the wood heater which was located in the lounge room.

Prior to going to bed, the adult female had placed a clothes horse containing children's clothing to be dried for school the next day, approximately 60-80cm from the side of the heater. A pair of trousers was also hung on a wire coat hanger on the decorative mesh surrounding the heater flue.

The investigation suggests that the wood heater was most likely burning at a very high temperature and that the flue of this heater was therefore extremely hot.

Given the above circumstances it was found likely that the trousers hanging on the flue caught fire either whilst hanging on the coat hanger, or the coat hanger burnt through causing the trousers to drop onto the top of the heater. The resultant fire would then have spread to nearby combustibles such as the clothing on the clothes horse and the curtains.

It was found the wood heater was in a condition not to the standard specified by the manufacturer as that there was a hole in the baffle plate. Added to this was the use of kiln dried off cuts of wood and the probability that the air control was left open. The culmination of these factors was found to have led to the heater and flue operating at an extremely high temperature. Ait was determined that this, associated with the dangerous practice of leaving clothing hanging close to the flue of the heater in all probability caused the fire.

COMMENTS/WARNINGS
"**I can only emphasise** the need for anyone with a wood heater to ensure that it is installed correctly, remains in a serviceable condition and is operated in accordance with the manufacturer's directions. I add **my warning** to those of many others that appropriate care and attention must be given when using heaters, be they wood fired or otherwise, to dry clothing. I encourage everyone to heed the various community service warnings and publications on this topic produced by Tasmania Fire Service and others."

DATA SOURCES

Data on the NCIS has been provided by each State and Territory Coroner's Office around Australia.

Additional codes are also provided by the Australian Bureau of Statistics (ABS)

Coroner's Court New South Wales	ACT Magistrates Court and Tribunals
Northern Territory Government Department of Justice	Coroner's Court of Western Australia
Queensland Government Office of the State Coroner	COURTS ADMINISTRATION AUTHORITY SOUTH AUSTRALIA
MAGISTRATES COURT OF TASMANIA	STATE CORONER VICTORIA

Note: In some States/Territories the Coroners Office is part of the Magistrates Court

FUNDING AGENCIES

Operational funding for the NCIS is provided by the following agencies:

Each State and Territory Justice/Attorney-General's Department
Australian Department of Health and Ageing
Australian Institute of Criminology
Australian Safety and Compensation Council
Australian Competition and Consumer Commission
Australian Transport Safety Bureau