Australian Government

Department of Health and Ageing

ACTING SECRETARY

Ms Kav Selvakumar
Coroners Registrar
Coroners Court of Victoria
Level 11
222 Exhibition Street
MELBOURNE VIC 3000

Dear Ms Selvakumar

RECOMMENDATIONS IN THE MATTER OF THE FINDINGS INTO THE DEATH OF AUDREY J SVIKERS – (CASE REFERENCE: COR2009 002158)

I refer to your letter dated 20 November 2012 seeking the Department of Health and Ageing's (the Department) response to the Coroner's recommendations (below) arising from the investigation into the Death without Inquest of Audrey J Svikers.

Recommendation 1:
That during initial needs assessment, community care providers advise community care clients that it is mandatory for all homes in Victoria to have a working smoke alarm.

Recommendation 2:
In homes where community care is to be provided and there is no smoke alarm, the installation of a small alarm is organised in line with service provision. In homes where smoke alarms are installed, these are checked by the community care provider to ensure they are in working order.

Recommendation 3:
That community care providers promote regular testing and maintaining of smoke alarms to the client, their family and/or friends or provide assistance for their clients to test and maintain smoke alarms if required.

Recommendation 4:
In homes where the client smokes, community care providers promote the use of high-sided ashtrays or sealed containers to allow for properly discarded smoking materials.

The Department notes that the Coroner's recommendations are consistent with the Community Care Common Standards (the Standards) as set out in the *Aged Care Act 1997* (the Act), in particular Expected Outcome 1.6: Risk Management and Expected Outcome 1.8: Physical Resources. The Standards provide a framework to ensure community aged care

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providers meet their requirements under the Act and continue to look for ways to improve their policies and practices.

The Department accepts that service providers, through appropriate risk management strategies, may help reduce the number of preventable residential fire fatalities involving older people who receive "in home" support to assist them to live in the community. In line with our practice to alert and educate community aged care providers on high risk matters, an alert has been issued to Commonwealth community care service providers to make them aware of the Coroner's recommendations and to remind them of their responsibilities under the Act. The alert suggests service providers make key personnel aware of the recommendations and take appropriate action.

The alert issued by the Department also contains reference to the complementary recommendations issued by Victorian Deputy State Coroner Iain West on 6 December 2012 in relation to the death of Pearl Recht. Ms Recht's death also resulted from a fire in her home.

A copy of the alert is attached for your information.

Yours sincerely

Rosemary Huxtable
Acting Secretary

\ February 2013