IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004397

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Marko Kelentric
Date of birth:	2 March 1947
Date of death:	12 August 2020
Cause of death:	1a: Effects of fire
Place of death:	21 Weston Street Beeac Victoria 3251
Keywords:	Fire, Fire Rescue Victoria, Country Fire Authority, smoke alarms, fire sprinklers, hoarding and squalor

INTRODUCTION

1. On 12 August 2020, Marko Kelentric was 73 years old when he died in a fire at his home. At the time of his death, Marko lived in Beeac with his friend, Joyce Cook.

2. Marko was born and raised in Ledenice, former Yugoslavia. In December 1970 at the age of 23, he arrived in Australia via a foreign refugee camp in Trieste, Italy. Marko did not have any family in Australia and corresponded with his siblings by mail.

3. In around 1989, Marko met Joyce whilst shopping in Geelong. Marko was never married and did not have any children. He had on numerous occasions asked Joyce to marry him, although she always declined.

4. That same year, Marko and Joyce moved into the residential property owned by Joyce in Beeac. They lived at the property until the date of the fatal incident, in almost isolation from others. They had long standing issues with several local residents in the Beeac area and were often involved in petty disputes.

5. On two separate occasions on 18 December 2018 and 29 January 2019, Marko and Joyce reported burglary incidents. Victoria Police formed the opinion that the 29 January 2019 burglary had been staged by the pair. Investigators were unable to locate any forensic evidence for either of the burglaries and both reports were closed.

6. Sadly, on 4 March 2021, Joyce passed away after suffering a stroke in late 2020 which had significantly affected her health

THE CORONIAL INVESTIGATION

7. Marko's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Marko's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. State Coroner Judge John Cain (as his Honour then was) originally held carriage of this investigation. I assumed carriage of this investigation for the purposes of conducting additional investigative steps, finalising the case, and making findings.

12. This finding draws on the totality of the coronial investigation into the death of Marko Kelentric including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

13. On the evening of 11 August 2020, Marko and Joyce went about their normal routine of eating dinner, cleaning and watching television. At approximately 9:30pm, they each went to sleep in their respective bedrooms.

14. During the night, Joyce stated that she awoke to the sound of *"psssttt"* and believed that she saw two images standing next to her dressing table dressed in black. She was scared and stayed in bed for around 5 minutes. She did not see the two images in her bedroom again.

[1] Subject to the principles enunciated in Briginshaw v Briginshaw (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

15. Joyce took her two small dogs onto the upstairs balcony and remained there for three or four minutes. When she re-entered the house, she saw flames near her bedroom. She was unable to access the landline phone located in her bedroom.

16. Joyce took the rope from the first-floor family room curtains and tied it to the dog box, which contained her two small dogs. She lowered the dog box over the edge of the balcony to the ground, outside of the garage. She then dragged a metal chair and table onto to the balcony and used it to climb over the waist height picket fence onto the roof at the front of the house. Joyce then proceeded to climb down a tree in front of the garage, the branch gave way and she fell to the ground.

17. Due to the amount of smoke inside the house, Joyce was unable to gain access to the house from the ground floor. She stated that due to poor telephone reception in the area, neither she nor Marko had mobile phones. As a result, Joyce drove her Mitsubishi sedan to the Beeac Police Station approximately 400 metres away. The station was unattended and although she used the emergency intercom system, she was unable to speak to anyone directly. Joyce then attended a public pay phone next door, which she used to call Triple Zero at 2:57am.

18. At approximately 3.06am, the Country Fire Authority (**CFA**) arrived at the property. Joyce advised the CFA members that there were three people in the house, two of which had broken in earlier that evening and started the fire. Because Joyce had not seen the two additional people since, the CFA *"proceeded with the knowledge of one male still inside the house*".

19. CFA members gained access to the property by using an axe to break open the roller shutters covering the left-hand side of the lounge room. A CFA member located Marko lying on his back on his bed, unresponsive. Marko was removed from the property through the bedroom window. He was placed on the driveway and CPR was commenced.

20. At approximately 3:30am, Victoria Police arrived on scene. Joyce was assisted to retrieve her third dog from the rear garden. She was treated for minor burns and transported to hospital for further treatment and observation.

21. At approximately 3:50am, Ambulance Victoria Paramedics arrived on scene. They examined Marko who was observed to unresponsive, not breathing and with no palpable pulse. He was declared deceased at 4.21am.

Identity of the deceased

22. On 12 August 2002, Marko Kelentric, born 2 March 1947, was visually identified by Leading Senior Constable William Boddington of Beeac Police Station.

23. Identity is not in dispute and requires no further investigation.

Medical cause of death

24. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body if Marko Kelentric on 13 August 2020. Dr Archer considered materials including the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, Victoria Police Section 27 request for immediate autopsy and scene photographs and provided a written report of her findings dated 5 January 2021.

25. The autopsy showed evidence that Marko was alive during the fire. The smoke inhalation product carboxyhaemoglobin was detected in post mortem blood, as was hydrogen cyanide a product of combustion of material such as plastics. Dr Archer noted that levels of these smoke inhalation products were sufficient to have caused death in isolation from other factors. The body was also affected by burn injuries, mainly seen to involve the head, hands and lower legs.

26. There was significant underlying cardiac disease, although in the setting of significant smoke inhalation and burns, this was not favoured to have contributed significantly to the death. However, the heart was enlarged for Marko's height and weight (cardiomegaly). There was also moderate to severe coronary artery atherosclerosis (blockage of the coronary arteries). Dr Archer commented that heart disease of this degree can be associated with lethal cardiac arrhythmia and sudden cardiac death.

27. Toxicological analysis of post mortem blood samples identified the presence of:

    i. Carboxyhaemoglobin ~ 65 % saturation

    ii. Hydrogen cyanide ~ 0.9 mg/L

    iii. Amitriptyline ~ 0.1 mg/L

    iv. Nortriptyline ~ 0.04 mg/L

    v. Amlodipine ~ 0.04 mg/L

vi. Metoprolol ~ 0.05 mg/L

28. Dr Archer provided an opinion that the medical cause of death was 1(a) EFFECTS OF FIRE.

FURTHER INVESTIGATION

29. The house was positioned in the front half of a large block, with sheds and animal pens in the back yard. A driveway extended along the northern boundary to the garage which was attached to the northern side of the house.

30. The house was a double storey with brick external walls, three bedrooms and metal tile/shingle roof. Marko slept in a downstairs bedroom and Joyce slept in the rear upstairs bedroom. The downstairs area of the house consisted of Marko's bedroom, a sitting room with a fireplace, a dining room, kitchen and loungeroom.

Victoria Police

31. Forensic Scientist Laura Noonan of the Victoria Police Forensic Services Centre examined the scene on 12 August 2020 and provided a statement detailing her findings. Ms Noonan observed that the house had been significantly damaged by the fire.

32. A CCTV security camera was located above the front door. However, due to the significant fire damage caused to the master bedroom, the hard drive was unable to be retrieved or located.

33. The front door appeared to have been closed at the time of the fire. It was unlocked at the time of Ms Noonan's examination, with no damage to the door, handle/locks, or frame to indicate any forced entry. The back doors, including security screen doors were closed and locked, with the laundry door being blocked by a refrigerator on the inside and an armchair on the outside. Ms Noonan observed that there was no external access from the ground to the first floor.

34. There were two smoke detectors located inside the house:

- on the ground floor located on a side table in the entrance way. The battery had been removed from the detector; and
- on the first floor located on a side table in the hallway. The battery had been removed from the detector.

35. While inspecting the property, Ms Noonan located a number of flammable items including:

- a rusted and soot damaged two-litre metal tin, uncapped, on the kitchen floor. An analysis of the contents detected 300 millilitres of petrol;

- a rusted five-litre metal tin, in a tree on the northern side of the garage. An analysis of the contents detected 125 millilitres of petrol with low levels of automotive diesel fuel; and

- a glass wine bottle, uncapped, on the floor in front of Marko's bedroom door. An analysis of the contents of the wine bottle detected two layers of liquid consisting of 25 millilitres of petrol with low levels of automotive diesel fuel and 5 millilitres of water.

36. Joyce told investigators that Marko would buy petrol and store it in a big tin drum inside the garage. She stated that the drum had a tap on the side which he would use to fill the mower and car directly. She was unable to recall him using the drum to fill other containers with fuel. However, she recalled that there were various containers around the property which may have been used to hold fuel in the past.

37. In her examination of the scene, Ms Noonan noted that the "*heaviest area of burning was in the north eastern corner*" of the lounge room, around the timber entertainment unit. Ms Noonan stated that "*the fire damage was more severe at the rear of the unit compared to the front*". The carpet under the entertainment unit had been largely protected by the fire, however, the section of carpet between the rear of the unit and the front wall had been consumed. In addition, the "*blinds on the front window…had been completely consumed…the roller shutter was closed, and the fire had burnt through the northern end of the shutter*".

38. Although there was significant fire damage on the first floor, the pattern of burning indicated that the fire had spread from the ground floor through the roof, and there were no other areas of burning on the first floor that were considered to be separate points of ignition.

39. Due to the extent of the burning to the timber furnishings near the entertainment unit, as well as the damage to the window and roller shutter, Ms Noonan concluded that the "*fire had started relatively low, or at ground level, behind the southern end of the entertainment unit*".

40. Joyce informed police that there were two power boards which were plugged into each other to control electrical devices within the entertainment unit, including the VCR player. This was

corroborated by body worn camera footage from 22 December 2018, when police attended the premises in relation to a reported burglary.

41. The VCR entertainment unit located in the loungeroom was examined by Mr Goran Sokoleski, Senior Engineer with Energy Safe Victoria. The VCR was substantially fire damaged and it was unable to be determined if it was on at the time of the fire. There did not appear to be any abnormalities with the VCR system.

42. Investigating police also examined a section of the foam and vinyl couch cover in the dining room which detected moderate-heavily evaporated petrol with levels of automotive diesel fuel. An analysis of Marko and his clothing, as well as Joyce, her clothing, and origin of the fire did not detect any flammable liquid residues.

43. At 10.30am on 30 September 2020, Ms Noonan reattended the scene at the request of the Victoria Police Arson and Explosive Squad in an attempt to locate additional fuel containers from the premises.

44. A twenty-litre metal drum with a plastic tap to the side was located and an analysis of the contents detected approximately 1.8 litres of petrol present. A yellow, round metal tin was also located in the garage with moderately evaporated automotive diesel fuel residue being present in the tin.

45. Investigators have been unable to locate any witnesses to or CCTV footage that depicts any person or persons at the property directly preceding the fire, other than Joyce. As a result, investigators were unable to substantiate Joyce's statement that there were unknown persons in the house directly prior to the fire. It is the opinion of the investigating police that Joyce's account of was caused by the sounds of the impending fire, flames and smoke.

46. Following an extensive examination of the scene, Ms Noonan concluded that "*the cause of the fire was the ignition of combustible materials in the lounge room, such as the carpet and curtains, as well as the surrounding furnishings. A second seat of fire in front of the ground floor bedroom door could not be excluded*". In regards to the possible second seat of fire, she considered it to be more likely that the petrol vapours from the wine bottle (of which some of the contents had spilt on the floor under it) were ignited via the heat from the fire in the lounge room, as the soot/heat layer had almost reached floor level.

47. Ms Noonan was unable to determine the source of ignition but considered that direct ignition by means such as a match of cigarette lighter to be most likely. She said:

"A*lthough flammable liquid was not detected in the area of the fire origin, the presence of petrol with low levels of automotive diesel fluid in the two uncapped containers inside the house and in the capped container located in the tree outside the deck/garage, as well as on the couch in the dining room, raised the possibility that flammable liquid had been poured around the entranceway (including the ground floor bedroom doorway and dining area). I considered direct ignition to be the most likely source of ignition.".*

48. She was unable to exclude a fault within an electrical appliance as a source of ignition but considered it less likely due to the result of the examinations of those items.

49. Despite a protracted police investigation, no forensic evidence was located to provide a nexus between any person and the cause of the fire.

Fire Rescue Victoria

50. An investigation was also undertaken by Fire Rescue Victoria (**FRV**) State Fire Investigation Unit. The State Fire Investigation Unit investigates all fire related fatalities in Victoria and is staffed by FRV operational staff members with specific training and qualifications in fire investigation.

51. FRV observed Marko's room to be heavily hoarded to roof level, classified as 8 on the Clutter Image Rating Scale (**CIRS**).[2] Marko was required to be removed via the window due to the clutter.

52. Other areas of the house were also cluttered, ranging from 2 to 9 on the CIRS. FRV noted the difficulty this posed to responding firefighters in accessing rooms to extinguish the fire.

53. Mr Geoff Kaandorp, Acting Manager of At Risk Groups, completed an FRV Prevention Report. He identified the following risk factors:

    i. Personal risks – person aged over 65, possible mental health related issues

    ii. Environmental risks – hoarding between levels 2-9 on the CIRS both internally and externally, no working smoke alarms, roller security window shutters

54. Mr Kandoorp made the following recommendations for the coroner to consider:

[2] The Clutter Image Rating Scale is a visual tool developed to help assess the severity of clutter in different areas of a home. It features a series of images ranked from 1 (least cluttered) to 9 (most cluttered). See for example: https://www.hoardingsqualormaroondah.org.au/wp-content/uploads/2016/12/clutter-image-rating-scale.pdf.

i. That the coroner maintains a watching brief on deaths which occur in homes in which hoarding and/or squalor are identified;

ii. That the coroner recommends the Victorian Government reconvene the Hoarding and Squalor Taskforce to:

- Explore how agencies across various sectors may be able to further coordinate their efforts to reduce risk for people affected by hoarding and/or squalor;
- Review and update the practical resource for service providers document; and
- Determine what advice and support agencies may be able to provide family members or other people supporting people who hoard to live more safely in their homes.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. Fire deaths in residential properties are unfortunately not a rare occurrence and are a significant public health issue. A 2019 report by the Bushfire and Natural Hazards Cooperative Research Centre, *Preventable residential fire fatalities: July 2003 to June 2017*, identified that on average, more than one fire-related death occurs in a residential context every week in Australia.

2. Deaths from residential fires have wide ranges impacts – socially, economically and emotionally – on individuals, families, communities and the emergency services who respond.

3. The Bushfire and Natural Hazards CRC study highlighted that the conceptualisation of fire fatality risk is complex, and it follows that so too is preventing it. The study noted that single risk factors alone are unlikely to significantly increase someone's risk of dying, but *it is the co-occurrence of a range of factors surrounding the person, their behaviours, their residential environment and other external factors that is likely to impact their overall level of risk of having a fire that results in their death.*[3]

[3] Coates, L et al. 2019, *Preventable residential fire fatalities in Australia: July 2003 to June 2017*, Bushfire and Natural Hazards CRC.

4. The report noted that the majority of preventable residential fire fatalities were found to be caused by human errors or unsafe behaviours. Preventable fires are defined as *fires where individuals, fire services or other stakeholders may have been able to identify the risks (related to a person and/ or a physical environment) and take actions or develop intervention strategies which, if applied, may have reduced the risk of a fire taking place.*

5. Marko's death appears to to fall within the above definition of a preventable fire. He had several risk factors contributing to his increased risk of dying in a fire, including that he experienced hoarding and squalor and his home did not have operable smoke alarms. I have kept these risk factors front of mind in considering the prevention opportunities that arise from his death.

6. I was assisted in my investigation and prevention role by Fire Rescue Victoria and the Country Fire Association, who I was grateful to meet with to discuss my investigation, and five other cases occurring in similar circumstances around the same time period as Marko's death. They provided me with important knowledge and insight and put forward recommendations for me to consider.

Hoarding and squalor

7. Hoarding is defined by the Department of Health as *..the persistent accumulation of and lack of ability to relinquish, large numbers of objects or living animals, resulting in extreme clutter in or around premises.* Hoarding was classified as a distinct disorder with its own diagnostic criteria in the 2013 edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association (DSM-5).

8. Squalor describes an unsanitary living environment that has arisen from extreme/prolonged neglect and poses substantial health and safety risks to people living in the affected premises and their neighbours.

9. Hoarding significantly increases the risk of fire in the home because for several reasons:

    i. The accumulation of items increases both the opportunity for ignition of a fire, and the fuel load for any fire that does occur;

    ii. Accumulated items block exits and narrow pathways, inhibiting egress of occupants and access for firefighters; and

iii. Accumulated items and lack of maintenance may lead to unsafe or non-functioning utilities and unorthodox and high fire risk practices related to cooking, heating, lighting and electrical use.

10. Fires in properties affected by hoarding also present an increased risk to firefighters responding:

i. High fuel load means a faster developing fire;

ii. Inhibited egress means the increased likelihood that a person may become trapped and require rescuing, which is an inherently risky activity; and

iii. Rescues in the context of hoarding are undertaken in an environment where access is limited and where structural damage from fire, resulting in building collapse, is more likely.

11. The Metropolitan Fire Brigade (**MFB**) (as it was then known) first identified hoarding as an emerging trend in late 2007, following three fatal residential fires in Melbourne within a four-month period where hoarding and/or squalor were identified as common features. Since then, the MFB and now FRV have undertaken a range of activities seeking to understand the risk and prevalence of fires associated with hoarding, engage agencies with a shared interest in and broader responsibility for addressing the needs of affected people, and reduce the risks to firefighters responding to fires in properties affected by hoarding.

12. FRV has a current, significant programme of work aimed at addressing the issues associated with hoarding and squalor. For example, agencies and individuals are able to make referrals to FRV where an increased fire risk has been identified at a residential property due to hoarding and/or squalor. A member of the At Risk Groups Unit will then provide advice on how to reduce the fire risk in the home environment. They also provide practical advice to the community via their website.

13. The Victorian Government had previously convened a Hoarding and Squalor Taskforce (**HST**) whose role it was to establish a framework and publish a guide to assist in the coordination of services to address hoarding and squalor in residential settings. It sought to promote a multidisciplinary approach and coordination across service providers and experts to address the individual risks and needs of people affected by hoarding.

14. In 2013, the HST published a guide *Hoarding and squalor: a practical resource for service providers*. The guide provided resources for service providers and promoted best practices for responding to hoarding and squalor. To my knowledge the guide has not been updated since its inception in June 2013.

15. Effective treatment and risk reduction in hoarding and/or squalor situations is highly complex. It often requires a service coordination approach to support the affected person over a long period of time, with engagement across multiple agencies. In many situations people with hoarding behaviour or who live in a squalid environment are not receptive to receiving services into the home, due to possible embarrassment, the condition of the property, as well as an overwhelming sense of the living environment being out of control.

16. I consider that a body such as the Hoarding and Squalor Taskforce is best placed to develop and identify the appropriate responses to hoarding and squalor. I will make a recommendation that such a body be reconvened, and that the 2013 hoarding and squalor resource is updated.

Smoke alarms

17. Smoke alarms are arguably the most important fire safety device – they are reliable, inexpensive and are mandated by law to be present in residential properties.

18. The Bushfire and Natural Hazards CRC report noted that the risk of death in a residential fire is higher in homes which do not have a smoke alarm. The Australian and New Zealand National Council for fire and emergency services (AFAC) reported in 2005 that the absence of smoke alarms can increase the possibility of a fatal fire by 60%, and low-income households are least likely to have a smoke alarm installed.

19. In 37 of the fire-related deaths in rental properties investigated by the Court, information was known about the presence of smoke alarm in 37 deaths. In 19 of those 37 deaths, a smoke alarm was either not present or was inoperable.

20. All Victorian residential properties must have smoke alarms installed on every level. If the property was built before 1 August 1997, they must be battery powered. If the property was built or majorly renovated after that time, they must be hard wired and have a back-up battery. Properties constructed or majorly renovated after 1 May 2014 are required to have interconnected, hard wired smoke alarms and have a back-up battery.

21. FRV advised me that they believe there are gaps in the current legislative and technical frameworks, which have been in the same form for many years and reflect minimum requirements. They noted that other Australian jurisdictions have additional requirements around smoke alarms such as requiring smoke alarms in bedrooms, interconnected smoke alarms in all residential buildings, and compliance checks upon property sale.

22. FRV and the CFA suggest that smoke alarms must:

- Meet the applicable Australian Standard (AS3786-2014);
- Be less than 10 years old;
- Operate when tested; and
- Be interconnected with every other required smoke alarm within the dwelling so all activate together.

23. They suggest that smoke alarms be installed in every living area and bedroom, including hallways and stairways, and be required in any garage that is connected to a building.

24. Of course, the utility of a smoke alarm relies on it being operable, which is not the case where the alarm has been tampered with or removed by the resident. FRV and the CFA have suggested measures that make removing or tampering with the smoke alarm more difficult, including flush mounting the alarm to the ceiling, the installation of damage stoppers over the alarm, and the use of 10-year batteries that are unable to be removed.

25. I will make a recommendation that the Victorian Government consult with FRV and the CFA to improve smoke alarm requirements.

Fire sprinklers

26. I consider improved smoke alarm requirements to be a significant prevention opportunity to reduce the risk of deaths in residential fires. However, the risk certainly still exists, particularly where the resident tampers with that smoke alarm or has other risk factors impeding on their ability to escape the fire, such as mobility issues or hoarding blocking egress.

27. In such cases, home fire sprinklers appear to be an obvious infrastructure improvement that may reduce fatalities, by allowing occupants extra time to escape or be rescued.

28. Fire sprinklers control the spread of fire significantly by reducing its size and damage but also have a positive environmental impact by reducing the size and amount of combustible material consumed by the fire, subsequently reducing the carbons and toxic gases released.

29. The evidence is clear that fire sprinklers save lives. According to a 2020 study by the US National Fire Protection Association that examined structure fires between 2017 and 2021, civilian death and injury rates in home structure fires were sprinklers were present were 89% and 31% lower, respectively, than in home structure fires with no sprinklers.[4]

30. The issue of fire sprinklers in residential buildings has previously been identified and discussed by Victorian coroners.

31. In November 2022, Coroner Simon McGregor handed down his finding into the death of DVR[5], a young boy who died at the Royal Children's Hospital from smoke inhalation from a fire at his apartment, owned by DFFH. Coroner McGregor made three recommendations, including, relevantly:

I recommend that the Department of Families, Fairness, and Housing (DFFH) consult with relevant organisations and conduct a feasibility study into whether fire sprinkler systems could be installed in all current (and future) public housing premises.

32. DFFH advised the Court that it supported the recommendation and agreed to work closely with relevant organisations to investigate whether it is feasible to install fire sprinklers in all current and future public housing properties.

33. In 2023, Coroner John Olle made a recommendation to the Australian Building Codes Board, which produces and maintains the National Construction Code:

I recommend that the Australian Building Codes Board commence consultation with other appropriate organisations to consider whether there is a strong rationale to amend the National Construction Code 2019 to require all new residential buildings, regardless of storeys or height, to have fire sprinkler systems installed to significantly reduce the risks and consequences from fire.

34. The Australian Building Codes Board replied to the recommendation, stating:

[4] McGree, T. 2024, *US Experience with Sprinklers*, National Fire Protection Association. Available at <https://homefiresprinklers.org.au/wp-content/uploads/2025/04/ossprinklers.pdf>.
[5] COR 2020 004470.

The [Australian Building Codes Board] recently commenced a process of stakeholder and community consultation on the opportunities and challenges related to new buildings in Australia. We have included a topic on Sprinklers, with a particular focus on home sprinklers, within that dialogue and we will work with relevant stakeholders and organisations to consider options.

35. Fire sprinklers are currently mandated in Class 2 and 3 buildings with a rise of four or more storeys, but not required in Class 1a dwellings[6], as was Nigel's home, and 1b dwellings[7].

36. FRV and the CFA have been advocating for home fire sprinklers, particularly in social housing, and have worked with the Home Fire Sprinkler Coalition Australia (**HFSCA**), the leading national resource for independent, non-commercial information about home fire sprinklers.

37. In doing so, FRV, the CFA and the HFSCA have identified barriers to the cost-effective installation of home fire sprinklers, including:

    - Water pipes and meters to a residential property are generally 20mm in diameter. Home fire sprinklers require a 25mm diameter pipe and meter to be effective. Water authorities do not have policies that support the installation of home fire sprinklers.

    - A lack of clarity as to who can design, install and certify home fire sprinklers.

38. I intend to make recommendations aimed at addressing these barriers. I also support the recommendations made by my colleagues. I encourage DFFH to install fire sprinklers in its properties where feasible, and for the Australian Building Codes Board to consider expanding the requirements for fire sprinklers to other classes of buildings in the next edition of the National Construction Code, expected to be released in 2028.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) With the aim of preventing like deaths and promoting public health and safety, I recommend that that the Department of Families, Fairness and Housing consider reconvening the

[6] A single dwelling being a detached house; or one of a group of attached dwellings being a town house, row house or the like.

[7] A boarding house, guest house or hostel that has a floor area less than 300 m^2 and ordinarily has less than 12 people living in it.

Hoarding and Squalor Taskforce with the aim of promoting best practice and inter-agency responses to hoarding and squalor.

(ii) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Department of Families, Fairness and Housing update and reissue the 2013 publication *Hoarding and squalor: a practical resource for service providers* or compile a similar publication for service providers.

(iii) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Government consult with Fire Rescue Victoria and the Country Fire Authority to introduce improvements to the smoke alarm requirements within the Victorian Building Regulations.

(iv) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Government consult with Fire Rescue Victoria and the Country Fire Authority to introduce an auditable regulatory compliance inspection process for domestic smoke alarms as part of the sale of residential property.

(v) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Building Authority publishes guidance to clarify who can design, install and certify home fire sprinklers to the FPAA101D specification.

(vi) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Department of Energy, Environment and Climate Action work with Victorian water authorities to develop policies that streamline the approval process to allow for the cost-effective installation of water meters that meet the pressure and flow requirements for home fire sprinklers to be installed.

(vii) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Department of Transport and Planning and the Australian Building Codes Board conduct research (either jointly or individually) in consultation with Fire Rescue Victoria, the Country Fire Authority and the Home Fire Sprinkler Coalition Australia into adopting home fire sprinklers to the FPAA101D technical specification within the National Construction Code (NCC), where not currently required under the NCC.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

a) the identity of the deceased was Marko Kelentric, born 2 March 1947;

b) the death occurred on 12 August 2020 at 21 Weston Street, Beeac, Victoria 3251;

c) I accept and adopt the medical cause of death ascribed by Dr Melanie Archer and I find that Marko Kelentric died from the effects of fire;

2. AND, having considered the available evidence, including that provided by Victoria Police and Fire Rescue Victoria, I am satisfied that the fire causing Marko Kelentric's death was caused by direct ignition in the loungeroom, and the resulting heat set alight improperly stored petrol outside of his bedroom.

3. AND, I find that the fire occurred in a home without operable smoke alarms, and Marko Kelentric's egress was impeded by significant clutter.

4. AND FURTHER, I am satisfied that Victoria Police have conducted a thorough investigation and there is no evidence of third party involvement in the fatal fire.

I convey my sincere condolences to Marko's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Department of Families, Fairness and Housing

Victorian Building Authority

Consumer Affairs Victoria

Department of Energy, Environment and Climate Action

Department of Transport and Planning

Australian Building Codes Board

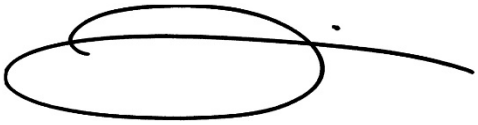
Fire Rescue Victoria

Country Fire Authority

Home Fire Sprinkler Coalition Australia

Senior Sergeant Steven Willer, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 4 March 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.