IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006787
COR 2022 006788

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	SR[1]
Date of birth:	[redacted]
Date of death:	26 November 2022
Cause of death:	1a: EFFECTS OF FIRE
Place of death:	[redacted], Werribee, Victoria, 3030
Keywords:	House fire, fire prevention measures, smoke alarms, fire sprinklers, rental properties

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased, and the names of other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication.

INTRODUCTION

1. On 26 November 2022, SR was 29 years old when she died in a house fire. At the time of her death, SR lived in Werribee with her housemate, Veeda. Veeda also perished as a result of the housefire.

Background

2. SR was born to parents AR and GR and was raised in Auckland, New Zealand. SR was assigned male at birth. She enjoyed leading a *'party'* lifestyle, was community-oriented and had *'no troubles forming new friendships'.*

3. After completing secondary school, SR began affirming her identity as female. Her brother describes this process as *'her biggest achievement'* and that she was *'proud to announce to the world that this is who she was'.* SR adopted a 'traditionally feminine' appearance, commenced gender-affirming hormone therapy and legally changed her name.

4. In 2022, SR moved to Melbourne and resided with her brother and his partner in Tarneit. Around August 2022, SR moved to a rental property on [redacted] Street in Werribee.

5. Veeda moved into the [redacted] Street residence with SR. The rear neighbour of the [redacted] Street residence recalls that *'every weekend they would have parties'* which would *'go all night'.* The neighbour recalls that the group, and their visitors, would smoke and be *'heavily drinking'.* Approximately two weeks prior to her death, SR and Veeda's friend, MT Tomasi (**MT**), came to stay with them.

THE CORONIAL INVESTIGATION

6. SR'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.

7. 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.

8. 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.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of SR'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.

10. Coroner Simon McGregor initially held carriage of the investigation into SR's death until it came under my purview in July 2023 for the purposes of obtaining additional material, finalising the investigation and handing down these findings.

11. This finding draws on the totality of the coronial investigation into the death of SR 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.[2]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. On 25 November 2022, at approximately 9pm, SR, Veeda and MT were at home drinking wine, of which they had purchased three casks, and smoking cigarettes. Around midnight, MT retired to his bedroom while *'SR and [Veeda] continued to smoke cigarettes and drink wine'* in the kitchen area.

13. At approximately 3am, MT was awoken by a noise. He went downstairs and saw SR and Veeda were still *'having fun'.* Around 5am, SR said she was tired and went upstairs to sleep. MT remained downstairs, where he commenced preparing a lamb roast, and Veeda stayed up speaking to friends online.

14. Around 7am, MT heard the smoke alarm by the front door go off. According to MT, *'[Veeda] went and removed the battery of the alarm'*. The smoke alarm upstairs was still going off and

[2] 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.

MT saw Veeda go upstairs. The rear neighbour also heard the smoke alarm coming from the residence around this time.

15. According to MT, Veeda called out, *'there's a fire in your room'*, to which MT responded, *'do you have a fire extinguisher?'* but received no reply. MT retrieved a bucket of water and went upstairs. He noticed *'thick, black smoke'* coming from his bedroom and could not locate SR or Veeda.

16. Through the smoke, MT located Veeda, unresponsive, and dragged them downstairs. According to MT, he commenced cardiopulmonary resuscitation (**CPR**) and once he saw *'saliva coming out of [Veeda's] mouth'*, placed Veeda in the recovery position.

17. MT returned upstairs to attempt to find SR but fell down the stairs and became unconscious.

18. When he awoke, MT *'went outside screaming for help'* and saw two passers-by. One of them contacted emergency services.

19. Shortly after 7:20am, crew members from the Country Fire Authority and Fire Rescue Victoria arrived at the residence. Firefighters entered the residence and carried Veeda to the front lawn where they performed CPR. At approximately 7:27am, paramedics arrived at the scene and upon assessing Veeda, found Veeda to be unconscious, not breathing and pulseless. They directed to cease CPR and declared Veeda deceased.

20. Subsequently, firefighters retrieved SR from the house, carried her to the front lawn and commenced CPR. Upon paramedics' assessment, SR was unconscious, not breathing and pulseless. They directed to cease CPR and declared SR deceased.

21. MT was transported to hospital and treated for smoke inhalation.

IDENTITY OF THE DECEASED

22. On 6 December 2022, scientist Dr Andrew Coventry (**Dr Coventry**) of the Victorian Institute of Forensic Medicine (**VIFM**) compared deoxyribonucleic acid (**DNA**) samples of the deceased against samples from SR's brother. Dr Coventry stated it was over 41 million times more likely the deceased and SR's brother were siblings than were unrelated. Dr Coventry also considered that the tattoos of the deceased were the same tattoos depicted in ante-mortem photographs of SR. Dr Coventry completed an Identification Report to this effect.

23. My colleague, Coroner Catherine Fitzgerald, reviewed the available evidence and determined that the cogency and consistency of all evidence relevant to identification supported a finding that the identity of the deceased was SR, born [redacted]. Accordingly, a Determination by Coroner of Identity of Deceased (**Form 8**) was issued on 6 December 2022.

24. I have considered the evidence relevant to the point of identification and comfortably conclude that the identity of the deceased is SR (whose full legal name is known to the Court).

MEDICAL CAUSE OF DEATH

25. Forensic Pathologist Dr Gregory Young (**Dr Young**) of the VIFM conducted an autopsy on the body of SR on 29 November 2022. Dr Young considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), post-mortem computed tomography (**CT**) scan and provided a written report of his findings dated 24 January 2023.

26. The post-mortem examination revealed superficial cutaneous burns to the upper body and soot in the airways. SR also had WHO Class III obesity with a body mass index of 50 kg/m^2.[3]

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

Ethanol (alcohol)	0.14 g/100mL
Carboxyhaemoglobin	~ 43% saturation in blood
Hydrogen Cyanide	~ 1.69 mg/L

28. Dr Young noted that fires, including fireplaces and gas stoves, produce carbon monoxide. When carbon monoxide is inhaled, it binds to haemoglobin in the blood, displacing oxygen. Consequently, haemoglobin cannot effectively carry and deliver oxygen to tissue, including vital organs. This leads to progressive asphyxia that results in cellular hypoxia in tissue, such as the brain and heart.

29. Dr Young stated that the presence of carboxyhaemoglobin and hydrogen cyanide in the blood indicated that SR was breathing when the fire was burning.

30. Dr Young provided an opinion that the medical cause of death was 1(a) *effects of fire*.

[3] The World Health Organisation (**WHO**) provides stratifies Body Mass Index (**BMI**) into categories of obesity. These categories range from underweight to Class I Obesity (with a BMI of 30.0–34.9 kg/m^2), Class II Obesity (with a BMI of 35.0–39.9 kg/m^2) and Class III obesity (with a BMI greater than 40 kg/m^2).

31. I accept Dr Young's opinion.

FIRE INVESTIGATION

Investigation conducted by Victoria Police

32. Laura Noonan (**FO Noonan**), a Forensic Officer of the Victoria Police Forensic Services Centre, also attended the [redacted] Street residence and conducted an investigation into the source of the fire.

33. FO Noonan was apprised of the circumstances of the fire and the recollection of events according to MT – including that MT was residing in the upstairs southern bedroom and was charging an iPad, which he said was on the bed.

34. According to FO Noonan, the property was *'relatively tidy'*. On the downstairs dining table, FO Noonan located various items including three boxes of cask wine, a cigarette lighter, cigarette papers, filters and tobacco.

Source of the Fire

35. There was fire damage to the bed in one of the upstairs bedrooms. FO Noonan did not identify any other areas of burning in the house that were indicative of additional points of ignition, nor was there evidence of flammable liquid present in the house.

36. In the bedroom, by the bed, there was a nearby power point which had devices plugged into each socket however, FO Noonan could not determine the nature of the devices.

37. FO Noonan observed electrical wiring and believed it was a charging lead for a laptop computer, iPhone or similar device. She also identified vapes and a cigarette lighter. One of the vapes had sustained significant fire damage while the other was heavily burned but retained most of its internal components including a lithium-ion battery.

38. The power point, electrical leads and vapes were sent to Senior Engineer Goran Sokoleski (**Mr Sokoleski**) of the Electrical Equipment Safety and Efficiency Department of Energy Safe Victoria. Mr Sokoleski examined the items *'for any evidence of abnormal operation that could have started or contributed to the starting of the house fire'*.

39. In his Electrical Equipment Examination Report, Mr Sokoleski concluded that *'from the inspection of the various electrical equipment and accessories provided, no signs or arcing or abnormal failure could be identified that may lead to the cause of the fire'.*

40. Having considered her observations at the scene and the report of Mr Sokoleski, FO Noonan concluded that *'the source of ignition was not determined'* but nonetheless, identified various potential sources. Such possibilities were the direct ignition of combustible materials, an electrical or other fault in an appliance, incorrect charging of a device or the ignition of combustible material by means such as a smouldering cigarette.

41. FO Noonan stated:

> *'The pattern and extent of fire damage in the southern bedroom indicated that the fire had originated from a single area of origin, being the southern (top) corner of the bed. This being the case, I considered ignition of the bedding and mattress materials as the result of a fault with an electrical appliance, either a vape or an iPad as suggested, to be the most likely source of ignition. A smouldering cigarette butt could also not be excluded'.*

Placement of Smoke Alarms within the [redacted] Street Residence

42. In Victoria, smoke alarms must be installed on every storey of a building and outside of sleeping areas.[4] However, they are not required to be installed in bedrooms. Fire Rescue Victoria and the Country Fire Authority recommend that all bedrooms be equipped with smoke alarms, noting that '*research has revealed that when a fire starts in a bedroom with doors closed, the smoke alarm outside the bedroom will not activate'*.[5]

43. On the ground floor, there was a smoke alarm mounted to the ceiling by the front door. According to FO Noonan, the cover was *'still attached but hanging down'* and there was a 9-volt battery fitted. I note that this conflicts with MT's recollection that Veeda *'went and removed the battery'* of this smoke alarm, although Veeda may have used another method to attempt to silence the detector.

[4] *National Construction Code,* Part 3.7.2.3 Location — Class 1a buildings.
[5] *See for example* 'Country Fire Authority – Smoke alarms are a bedroom essential'. Accessible at: https://www.cfa.vic.gov.au/plan-prepare/fires-in-the-home/smoke-alarms/smoke-alarms-are-a-bedroom-essential#:~:text=Some%20people%20think%20the%20smoke,the%20bedroom%20will%20not%20activate.

44. The removal of batteries from smoke alarms is strongly discouraged by fire safety authorities including Fire Rescue Victoria and the Country Fire Authority. However, there is no evidence that faulty or inoperative smoke alarms contributed to SR and Veeda's deaths. While Veeda's decision to silence the smoke alarm (potentially by removing battery) was contrary to best practice, evidence indicates Veeda did so after the fire started and once it had already activated.

45. There were two smoke alarm brackets on the upstairs ceiling at either end of the staircase. One of these brackets was situated outside of the southern bedroom, where the fire began. Two heat-affected smoke alarms, each fitted with a 9-volt battery, were located – one on the floor of one of the upstairs bedrooms (not the bedroom in which the fire started) and one in the backyard. FO Noonan believed these smoke alarms were originally connected to the upstairs ceiling brackets.

46. FO Noonan opines that the smoke alarm located in the backyard was originally located outside the bedroom where the fire started. This is confirmed by the evidence of Senior Station Officer Mark Gauchi of Fire Rescue Victoria that the smoke alarm was originally upstairs and operating correctly but was thrown out the window. According to Commander Mark Collins of the Country Fire Association (**Commander Collins**), *'a practical assumption for this action would be that the noise would have been impacting the ability of the crews to communicate easily'.*

Investigation conducted by the Country Fire Association

47. Commander Collins attended the [redacted] Street residence and inspected the scene alongside FO Noonan. He completed a Structural Report for the Fire & Incident Reporting System, and made largely the same conclusions.

48. Within the house, Commander Collins identified several cigarette butts and *'smokers' materials'* in the dining and kitchen area.

49. Upstairs, in the southern bedroom, Commander Collins noted *'obvious fire damage to the bed with the southern corner of the bed and adjacent bed head and plaster consumed in that corner'*. He formed a belief that *'the area of origin is in or directly adjacent to the southern corner of the bed'.*

50. When contemplating the cause of the fire, Commander Collins opined that a *'smouldering cigarette butt cannot be discounted'*, an electronic device could have overheated or experienced *'some other failure'* or a vape which was discovered in the bedroom.

51. Mr Collins located two smoke alarms in the upstairs landing and confirmed they *'eventually activated'* however believed that this occurred *'either after the fire burnt through (or at least distorted the door to [the bedroom] or small amounts of smoke pushing under the fire door was sufficient to activate the alarm'.* Commander Collins added, *'if there had been smoke alarms fitted in each of the bedrooms (. . .) there would have been far earlier notification to the occupants of the fire*'.

52. Commander Collins did not make any recommendations in his Structural Report.

THE PREVALENCE OF FIRES IN RESIDENTIAL RENTAL PROPERTIES

53. Upon reading the coronial briefs in relation to SR and Veeda's deaths, I noted that the lethal consequences of the fire that broke out in the [redacted] Street residence form part of a broader category of fatal fires in residential rental properties. In exploring this category, I sought the assistance of the Coroners Prevention Unit (**CPU**) to provide me with data and statistics on its prevalence.[6]

54. From its databases, the CPU identified that between 2010 and 2024 there were 50 deaths due to unintentional fires at residential rental properties. In 37 (74%) of these deaths, there was data available regarding the presence of smoke alarms in the building. Of these 37 deaths, in 19 (51%) of them, a smoke alarm was either absent or not working at the time of the fatal fire.

55. As discussed above, there is evidence that the [redacted] Street residence was properly fitted with smoke alarms and that they were operational at the time of the fire. Additionally, the CPU data indicates that 49% of fatal house fires occurred despite working smoke alarms (amongst the cases where that information is available). Given that smoke alarms alone cannot be considered adequate protection against fatal fires, I turned to consider additional prevention opportunities.

[6] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health; as well as staff who support coroners through research, data and policy analysis.

THE USE OF SPRINKLER SYSTEMS IN RESIDENTIAL BUILDINGS

56. In addition to the above statistics, the CPU provided me with research regarding the use of sprinkler systems in Victorian residential buildings.

57. The National Construction Code requires sprinkler systems in buildings over 25 metres in height and in residential buildings of four storeys or higher. While no Australian State or Territory has mandated sprinkler systems in all residential buildings, it comes recommended by multiple fire safety authorities nationwide.

58. Fire & Rescue New South Wales suggest that all new residential buildings up to 25 metres in height should have sprinkler systems installed. Research indicates that while smoke alarms play an important role and have had a significant impact in reducing the number of fatalities in residential fires over the past 10 years, a combination of sprinkler systems and smoke alarms markedly improves the safety of occupants in the event of a fire.[7]

59. The Home Fire Sprinkler Coalition Australia's *'Strategy 2021-2025'* is focussed on engaging the Australian Building Codes Board to advocate for further changes to the National Construction Code to introduce fire sprinkler systems into more residential building classes.[8]

60. The mandating of sprinkler systems in residential builds has been adopted internationally and has resulted in a reduction in fire-related fatalities including in North America and the United Kingdom. Since 1986, in Scottsdale, Arizona, all new single and multi-family houses are required to have an automatic sprinkler system. A 15-year study was conducted on the efficacy of the sprinkler systems and found that the civilian fire fatality rate was reduced by at least 50% and greatly reduced the economic loss suffered by families due to fire damage.[9]

61. In recent years, the need for sprinkler systems in Victorian residential buildings has been discussed by my fellow coroners. These discussions have centred largely on private rental accommodation and public housing.

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[7] Fire & Rescue New South Wales, 'Fire research report – Residential Sprinkler Research', <https://www.fire nsw.gov.au/gallery/files/pdf/research/FRNSW%20Residential%20Sprinkler%20Research%20Report.pdf>.

[8] Home Fire Sprinkler Coalition Australia, Strategy 2021 – 2025, https://secureservercdn.net/45.40.148.117/bje.01a.myftpupload.com/wp-content/uploads/2021/10/HFSC_Strategy_2021-09-19.pdf.

[9] City of Scottsdale, 'A 15 year update on the impact and effectiveness of the Scottsdale Sprinkler Ordinance', https://www.scottsdaleaz.gov/Assets/ScottsdaleAZ/Fire/15yearsprinklerexecstudy.pdf

62. Of particular note, in 2023, my colleague Coroner John Olle handed down a recommendation to the Australian Building Codes Board, which produces and maintains the National Construction Code. The recommendation reads:

> *'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.'*[10]

63. On 4 October 2023, Gary Rake, Chief Executive Officer of the Australian Building Codes Board stated that:

> *'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.'*

64. In May 2024, the Australian Building Codes Board invited public submissions on the *'significant amendments'* which they propose to make in the 2025 edition of the National Construction Code. Of the 17 changes, home sprinkler systems were not listed. Public comment closed on 1 July 2024. The next edition of the National Construction Code will be released in 2028.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was SR (whose full legal name is known to the Court), born [redacted];

b) the death occurred on 26 November 2022 at [redacted], Werribee, Victoria, 3030, from 1(a) *effects of fire*; and

c) the death occurred in the circumstances described above.

[10] COR 2020 003017.

66. I have considered the circumstances of the fatal house fire which occurred in the morning of 26 November 2023, including the reports provided by Forensic Officer Laura Noonan and Commander Mark Collins, and find that the fire was most likely caused by an electrical device situated in the southern upstairs bedroom, likely a vape, iPad or similar device, or by a smouldering cigarette. The weight of the available evidence does not support a precise finding regarding the mechanism of ignition.

67. I note and agree with the conclusion of investigators that, whilst deliberate direct ignition of the fire by match or cigarette lighter cannot be completely eliminated, there was no evidence to support that the fire occurred on this basis or that there were any suspicious circumstances connected with the fire.

68. The evidence indicates that the residence was fitted with smoke alarms, and that they were operational at the time of the fire and were fitted in accordance with the applicable regulatory framework. No adverse findings are warranted in the circumstances; however, a pertinent comment will follow.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments on matters connected with the deaths:

1. In my view, the deaths of SR and Veeda demonstrate that a significant opportunity exists to consider further options to improve the safety of community members and to guard against the often-horrific impacts of fires in residential homes in Victoria, including via: (i) the consideration of mandating sprinkler systems in residential homes; and/or (ii) mandating the fitting of smoke alarms in bedrooms.

2. The need for further consideration of such options is demonstrated by the circumstances of the present case in which smoke alarms appear to have been fitted and positioned correctly, and eventually activated, but those inside the residence were heavily affected by alcohol and, as is not infrequently the case, were therefore not well-positioned to extricate themselves from the catastrophic situation that unfolded. In addition, the evidence of Commander Collins supports that if there had been smoke alarms fitted in each of the bedrooms, there would have been far earlier notification to the occupants of the fire.

3. I consider that Fire Rescue Victoria (**FRV**) and the Country Fire Association (**CFA**) are best-positioned to provide advice and guidance on these issues to Government, including as to any

changes that may be required to the applicable regulations and construction codes. Not only were FRV and CFA part of the first response team to this particular incident, and provided an analysis as to the possible causes of the fire, but their organisational purposes also include the effecting of systemic change to the built environment through reforms to building design, regulations and legislation.

4. Accordingly, I note and endorse the ongoing discussions that are being led by FRV and CFA in relation to strengthening the regulatory framework governing fire sprinkler systems in residential homes in Victoria, along with consideration of the mandated fitting of smoke alarms in bedrooms. I have elected to publish the present finding and to notify the Australian Building Codes Board, Victorian Building Authority and Home Fire Sprinkler Coalition Australia, to assist in informing future deliberations in this space, along with any additional community education considered to be required.

I convey my sincere condolences to SR's family for their loss, and to the broader LGBTIQA+ community for loss of two of its community members in this tragic housefire. I also acknowledge the extensive, brave and dedicated efforts of first responders to this incident.

ORDERS AND DIRECTIONS

Pursuant to section 73(1A) of the Act, I direct 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:

GR, Senior Next of Kin

AR, Senior Next of Kin

Australian Building Codes Board

Fire Rescue Victoria

Country Fire Authority

Victorian Building Authority

Home Fire Sprinkler Coalition Australia

Senior Constable Emma Hockey, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date: 14 February 2025

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.