IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 003017

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

**Amended pursuant to section 76 of the Coroners Act 2008 (Vic) on 13 April 2026 by order of the State Coroner Judge Liberty Sanger*

Findings of:	Coroner John Olle
Deceased:	Michael Alan Holmes
Date of birth:	13 February 1986
Date of death:	7 June 2020
Cause of death:	1(a) effects of burns
Place of death:	Alfred Health, the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004
	House fire, likely source of ignition wood heater burning nearby clothes and towels, insufficient smoke alarms

* *Amendment on page 1 to correct a typographical error*

INTRODUCTION

1. On 7 June 2020, Michael Alan Holmes was 34 years old when he died at Alfred Hospital following burns sustained from a house fire. At the time of his death, Michael lived at his home with his wife Nicolina and their three children, Louis, Harvey and Rafael.

THE CORONIAL INVESTIGATION

2. Michael'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.

3. 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.

4. 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.

5. Victoria Police assigned Leading Senior Constable Gogorossis to be the Coroner's Investigator for the investigation of Michael's death. The Coroner's 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.

6. This finding draws on the totality of the coronial investigation into the death of Michael Alan Holmes 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]

[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.

** Amendment on page 1 to correct a typographical error*

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

Circumstances in which the death occurred

7. Michael met and married his wife Nicolina (**Nicci**), and together they had three children: Louis, Harvey and Rafael. On Saturday 6 June 2020, the family had plans to attend Nicci's parents' holiday house in Tyaak.

8. In 2008, Joe and Donna Lolicato purchased the property located at 160 Cunninghams Road, Tyaak (**the farm**). The farm is a five-acre property located approximately seven and a half kilometres east of Broadford. When owners Joe and Donna purchased the farm in 2008, a log cabin had been built on the property. It was constructed with treated pine logs on the exterior with pane panels on the interior and a laminated carboard lining on the ceiling. Joe and Donna established various sheds, a vegetable garden and horses on the property.

9. Over the years Donna and Joe extended the original dwelling by adding a corrugated iron structure to the rear of the existing log cabin. The updated structure consisted of three bedrooms, a bathroom and a loungeroom in the log cabin section, and an updated kitchen, family room and extra bedroom in the corrugated iron section. The corrugated iron section of the dwelling was built on a concrete slab and lined on the inside with plaster board.

10. On Friday 5 June 2020, Joe and Donna arrived at the farm at approximately 2.00 pm. They prepared the house, which involved turning on the gas supply and the hot water unit. Joe lit the wood heater inside the house, tended to his vegetable garden and fed the horses. Donna cleaned the house and prepared dinner.

11. On Saturday 6 June 2020, various family members and friends arrived. Joe and Donna's son, Tony, arrived with his close friend Daniel. Tony's wife Kristen, and their three children, Joey, Eva and Luca had already arrived. Joe and Donna's daughter, Nicci, arrived with her husband Michael and their three children, Louis, Harvey and Rafael.

12. They spent the afternoon together, with most of them going for a drive around the properties while Donna prepared dinner and did a load of washing, mainly towels, that she then hung on the clothes rack placed in front of the Coonara wood heater in the front lounge room.

13. Once everyone reconvened at the home, they all ate dinner together and the children were bathed and put to bed. Joe, Tony and Daniel went to the garage and conducted some maintenance on the ride-on mower. They consumed a small amount of alcohol and Tony and

Daniel smoked some cannabis. Everyone else remained in the house. Between 9.30 pm and 10.00 pm, Joe, Tony and Daniel returned to the house and watched television. Everyone else had already gone to bed. Between 10.30 pm and 11.30 pm, Joe, Tony and Daniel went to bed. They left the fire in the wood heater burning. The clothes were still drying on the rack in front of the heater. There may have also been a towel or towels hanging from metal hooks affixed to the chimney flue, and this was a common practise carried out by the owners and visitors over many years.

14. On Saturday 6 June 2020, thirteen people were asleep in four bedrooms throughout the house at the farm. Michael woke up and saw the fire. He ran through the house screaming 'fire' and banging on doors to wake everyone up. The fire was observed to be burning intensely and spreading quickly along the ceiling of the loungeroom in the front section of the house.

15. Eleven of the occupants were able to successfully evacuate the property. Kristen smashed a window to get out with her two children, as they were unable through the door owing to the intensity of the fire in the loungeroom.

16. Once outside, it was established that Daniel and Louis were still inside the burning house. Tony tried to wake Daniel by banging on his bedroom window from the outside, but he could not see or hear Daniel.

17. Michael then re-entered the house attempting to rescue his son, Louis, but was unable to locate him. Sadly, as a result of re-entering the home, Michael sustained severe burn injuries to the whole of his body. By this time, the fire had engulfed the house.

18. At about 11.30pm, neighbours observed the fire and contacted emergency services, and then attended the property to render assistance. Michael told one of them that he had tried his best but he could not get his son out of the house, and further said that they had been drying clothes in front of the Coonara wood heater and they had caught on fire.

19. At 11.52 pm, the first fire unit arrived on scene. Firefighters were unable to enter the house however overheard someone (thought to be Donna) say that she had left clothes too close to the heater. This sentiment was echoed by others who had been sleeping at the farm. Shortly thereafter, members of Victoria Police attended the property.

20. At 12.15 am, the first ambulance arrived on scene and paramedics began treating the injured. As this happened, police began speaking to the occupants of the house. Many of them

referenced the clothes that had been drying in front of the wood fire, and Tony suggested that the towel affixed to the cook of the Coonara may have contributed to the start of the fire.

21. Tragically, the bodies of Louis Holmes and Daniel Sassone were found in separate areas of the property. They could not be saved and were already deceased.

22. Michael initially survived the fire, though suffered serious burns and was airlifted to Alfred Hospital. He had suffered burns to approximately 90 percent of his total body surface area. Tragically, he succumbed to his injuries on 7 June 2020.

Examination of the site of the fire

23. At 7.40 am on Sunday 7 June 2020, forensic scientist, George Xydias of the Victoria Police Forensic Science Centre – Fire and Explosion Unit, attended the property and conducted an examination of the scene, assisted by Forensic Officer Gonzalez, Fire Investigator Smith, Detective Senior Constable Gogorossis and Detective Sergeant Dean.

24. Mr Xydias provided two statements to the Court regarding his assessment of the fire and the likely source of ignition.

25. After an examination of the scene, Mr Xydias concluded that there appeared to have been a single fire started across the south-western quarter of the lounge room, beside the front corner of the wood heater. There was an intense localised area of burning over several square metres of the flooring around this region, between the clothes rack(s) and the towel remnants beside the fire screen. From the pattern and extent of burning throughout the interior, there was no indication of the presence of flammable liquid in this (or any other) room for the purpose of initiating, spreading or fuelling the fire.

26. Mr Xydias concluded that the probable cause of the fire was the ignition of the localised available combustible materials/fixtures, such as the timber floorboards and/or other floor coverings, the various timber and metal framed furnishings/contents, the plastic covered electrical appliances/objects and any papers or clothing items in the region.

27. Mr Xydias could not determine the source of the ignition, however considered that there were likely four main possibilities.

28. Firstly, Mr Xydias opined that the source of the ignition could have been a firewood or wood heater related incident. The towel was in contact with the flooring and immediately beside the clothes rack(s) within the area identified as the seat of the fire. Additionally, the heater had a

* *Amendment on page 1 to correct a typographical error*

considerable amount of charred wood/ash inside (indicating recent use). Mr Xydias concluded that the wood heater clothes drying activity was the most likely means of ignition.

29. Secondly, Mr Xydias opined that an indeterminate accidental source, such as a carelessly discarded or dropped cigarette butt, match or similar smoking-related item or candle could have been the source of the ignition. This alternative is dependent on whether someone in the house had recently smoked and/or had used a candle or similar means of lighting. While no remains of any candles or smoking-related activities were apparent, Mr Xydias could not exclude this as a remote possibility.

30. Thirdly, Mr Xydias opined that the source of the ignition could have been by an appliance or the associated wiring in the vicinity of the television or overhead light. The electrical appliances identified within about a three metre radius of the seat of the fire were the flat screen television and the overhead light. Each of these electrical devices was effectively destroyed, damaged to such a state that it was impossible to determine the brand or what condition it had been in prior to the fire. Given the level of destruction to these appliances and the associated wiring, it is not possible to exclude any of these electrical items as a potential ignition source, though Mr Xydias considered that this was only a remote possibility.

31. Finally, Mr Xydias concluded that the source of the ignition could have been direct, by way of a match or cigarette lighter. While it was not possible to exclude deliberate ignition, there was no evidence to substantiate this scenario.

32. In his supplementary statement, Mr Xydias advised that, at the time of the examination of the scene, he was not aware of any hooks affixed to the chimney flue. While there were no identifiable remains of any hooks, or similar items, apparent in the vicinity of the heater, given the exceptionally severe burning and extent of destruction throughout the house, it is possible that there were small hooks which were completely burnt away or otherwise disintegrated. Metals such as aluminium, brass and some alloys will ignite and burn when exposed to prolonged and/or elevated temperatures (such as this fire). Similarly, more fire-safe polymers and similar materials will also decompose or be consumed in such circumstances. In this case, ferrous-based metals would not be consumed; however, no such hook/implement was present on the flue or near the heater.

33. Mr Xydias ultimately opined that a wood heater-related fire involving the activity of drying/heating towels and clothes, either on the flue itself or immediately beside the heater on a clothes rack is considered the most likely means of ignition. The use of the flue in this

fashion is hazardous and not recommended, nor is the close proximity of the clothes rack to the heater. It is dangerous to leave such a situation unobserved. If the heater was operational and utilised in this manner, it is conceivable that most of the items of clothes and towels would easily ignite and fall onto the heater and the floor or other items beside it. All forms of common cloth materials are readily ignitable and would effectively be consumed during the ensuing fire. In this case, however, it was not possible to determine where the discovered towel material on the floor had originated.

34. Finally Mr Xydias concluded that there was no evidence of any hard-wired or battery powered smoke detector found in any room, though noted that the level of destruction and effective consumption of most of the combustible furnishings, fitting and other contents throughout the house meant that any such smoke detector would also have been destroyed or concealed under the fallen debris.

35. I accept and adopt Mr Xydias's opinion.

<u>Conclusion of Coroner's Investigator</u>

36. Detective Senior Constable Gogorossis made several conclusions about the cause of the fire at the farm. He concluded that the fire in the wood heater was left burning and unattended when the occupants went to bed. Towels and clothing items had been left dying on a clothes rack in front of the wood heater when the house's occupants went to bed. It was common practice to hang items of clothing or towels on the metal hooks affixed to the chimney flue for them to dry, and it is likely that there was at least one towel hanging from the hook on the chimney flue when the occupants retired to bed.

37. In the circumstances, the most likely cause of the fire originating in the front lounge room area of the house was the accidental ignition of towels and/or clothing items left to dry in front of the wood heater and/or a towel or towels left to dry on the metal hooks affixed to the chimney flue of the wood heater.

38. It could not be determined if the smoke alarm installed in the new section of the house activated or was in operational order at the time of the fire. There is no evidence so suggest any suspicious involvement or activity regarding the fire.

39. I accept and adopt Detective Senior Constable Gogorossis's conclusion.

* *Amendment on page 1 to correct a typographical error*

Identity of the deceased

40. On 7 June 2020, Michael Alan Holmes, born 13 February 1986, was visually identified by his brother, Stephen Holmes.

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

Medical cause of death

42. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 8 June 2020 and provided a written report of his findings dated 16 June 2020. Dr Burke also reviewed the medical deposition, the post-mortem computed tomography scan, the Victoria Police Report of Death (**Form 83**) and the Donate Life form.

43. Toxicological analysis of post and ante-mortem samples identified the presence of fentanyl (~ 2 ng/mL), morphine, free (~ 0.2 mg/L), ketamine, lignocaine, midazolam (~ 0.1 mg/L) and ondansetron (~ 0.2 mg/L).

44. Dr Burke provided an opinion that the medical cause of death was 1 (a) effects of burns.

45. I accept and adopt Dr Burke's opinion.

CPU REVIEW

46. I referred this matter to the CPU to collate data on all fatal house fires between 1 January 2010 and 31 August 2022, which were started when a heater ignited a nearby item such as clothing, furniture of similar.[2]

47. The CPU used the Coroners Court of Victoria surveillance database to identify all relevant Victorian deaths. For each death that met the inclusion criteria, the CPU reviewed the Victoria Police Report of Death for the Coroner (**Form 83**) and, where available, the electronic coronial brief or coronial finding and recorded the deceased's sex and age, the type of heater involved, and the object ignited. There were some limitations, primarily that for deaths still under investigation the CPU had to rely solely on the Form 83 to identify the circumstances

[2] 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.

of the source of ignition and the object ignited. This is an information source that varies widely in detail and quality. Therefore, one reason that there are fewer deaths recorded for 2021 and 2022 may be due to the limited information available in the Form 83.

48. The CPU identified 23 deaths of people from 18 incidents in house fires between 1 January 2021 and 30 September 2022 where the ignition point was a heater. The CPU also identified one further death where the ignition source was a Coonara fireplace.[3]

49. CPU also contacted Fire Rescue Victoria (**FRV**) on my behalf and established whether they produced a prevention report on the fire in question. FRV confirmed that the fire was investigated and their report was provided to me as part of my investigation.

50. The Country Fire Authority (**CFA**), which is a division of FRV, submitted a further report dated 9 April 2019 regarding smoke alarms in residential properties and the updated position from the Australasian Fire and Emergency Service Authorities Council (**AFAC**). AFAC's recommendations included the following:

    a) Smoke alarms be installed in every living area and bedroom (including hallways and stairways)

    b) Where more than one smoke alarm is installed in a property, they should be interconnected

    c) The number, location and interconnection of working alarms is more important than the type/technology of installed smoke alarms in achieving positive safety outcomes

    d) The responsibility for monthly smoke alarm testing rests with the occupant. The responsibility for annual battery replacement and cleaning should rest with the occupant in the case of an owner-occupied property, and in the case of the landlord/owner in rental and short-term accommodation properties.

51. CFA endorsed the development of a transitional approach to adopt the AFAC position. The CPU notes that, while these recommendations may be noteworthy, there is not a strong rationale to make them in this particular case as there was no evidence of working smoke alarms in the premises. If working smoke alarms were in the premises and the deaths still

[3] COR 2020 2747.

** Amendment on page 1 to correct a typographical error*

occurred, then I would consider these recommendations more compelling for this particular matter.

52. The CPU has identified national and international evidence which suggests that fire sprinkler systems in residential homes saves lives. Currently in Australia, the National Construction Code (2019) requires sprinklers in all buildings over 25 metres in height, as well as all residential buildings of four storeys or higher.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Michael Alan Holmes, born 13 February 1986;

   b) the death occurred on 7 June 2020 at Alfred Health, the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from effects of burns; and

   c) the death occurred in the circumstances described above.

COMMENTS

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

54. A tragedy such as this compels me to remind the general public of the dangers of drying clothes near an open fire, unobserved. It is crucial that inflammable material is kept away from heaters, open fires and wood fires for the safety and protection of all occupants of the building.
55. I acknowledge and commend the heroism and bravery of Michael Holmes who lost his life attempting to save the lives of others.

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

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

Nicolina Holmes, Senior Next of Kin

Leading Senior Constable Gogorossis, Coroner's Investigator

* *Amendment on page 1 to correct a typographical error*

Signature:

Coroner John Olle

Date : 06 July 2023

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.

* *Amendment on page 1 to correct a typographical error*