IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 007232

FINDING INTO PASSING WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	UYB[1]
Date of birth:	2011
Date of passing:	19 December 2022
Cause of passing:	1a: Effects of fire
Place of passing:	Forest Road North, Lara, Victoria, 3212
Keywords:	Housefire, smoke alarms, fire prevention measures

Aboriginal and Torres Strait Islander readers are advised that this content involves a deceased Aboriginal person. Readers are warned that there may be words and descriptions that may be culturally distressing.

[1] This Finding has been de-identified by order of Coroner Dimitra Dubrow 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. UYB was 11 years old when he passed in a house fire on 19 December 2022. He is survived by his parents, KDB and VGB, and his siblings.

2. A family friend, NGN, died in the same fire. UYB's 10-year-old younger brother, FMB, was also in the house at the time of fire and survived.

3. UYB was a proud Aboriginal boy who had a strong connection with his culture. He was a keen and competitive sportsman and was voted by his peers to be school sport captain for Grade 6. He was a member of his local cricket and football clubs and was a social club member of the Geelong Cats Football Club.

4. The house fire occurred at NGN's house. NGN was known by the family for over 10 years from when they lived next door to each other. The two boys and KDB continued to spend a lot of time at NGN's house after they had moved address.

THE CORONIAL INVESTIGATION

5. UYB's passing 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.

6. 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.

7. 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.

8. Judicial Registrar Katherine Lorenz, then coroner, initially held carriage of this investigation. I took carriage of this matter upon my appointment in September 2024 and following Judicial Registrar Lorenz's appointment to the Supreme Court of Victoria.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of UYB's passing. The Coronial Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the passing of UYB 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]

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

Circumstances in which the passing occurred

11. On 18 December 2022, UYB and FMB asked KDB if they could go to NGN's house to watch the soccer World Cup.

12. At 9:30pm, the family arrived at NGN's house.

13. At about 10pm, KDB left to have a night out with a friend.

14. At about 2:30am, 19 December 2022, KDB returned to NGN's house to take the boys home. At the time, FMB was asleep, but UYB was still awake and still watching the soccer with NGN in the lounge room. UYB asked to stay to keep watching the soccer to which KDB agreed. KDB kissed UYB and FMB goodbye and planned to return in the morning.

15. It was not unusual for the boys to stay over at NGN's house. They would sleep in the lounge room which was directly adjacent to the master bedroom.

16. FMB did not provide a statement but recounted the subsequent events to his mother who provided multiple statements of these conversations, including one taken at the scene.

17. FMB told KDB that he was asleep on the couch in the lounge room when he woke up hearing glass breaking and smelling smoke. FMB then ran into the bedroom yelling to NGN to get UYB out and recalled seeing NGN *"whacking at the bed"*. He recalled seeing that the fire

[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.

was confined to NGN's bed at this stage. NGN then reportedly said words to the effect of *"I was in the Army, I'll get him [UYB] out"*. FMB then ran out to the front of the property.

18. Based on later investigation of the scene, it appears that NGN attempted to extinguish the fire with a towel, before getting a fire extinguisher from the kitchen. Unfortunately, he became incapacitated before he could use the extinguisher.

19. At about 4:30am, a passerby stopped in their car after noticing the housefire while driving. They observed flames coming out of the windows and up as high as the roof with a lot of smoke coming from the house. They called Triple Zero and waited for emergency services to attend.

20. However, shortly after the phone call, they saw FMB out the front of the property. FMB reportedly told the passerby that *"it was his pop's house and that his pop had gone to wake UYB as he wouldn't wake up"*. They drove FMB home and then both KDB and FMB back to NGN's house.

21. At 4:44am, and while the family were returning to the house, members from Fire Rescue Victoria (**FRV**) had arrived on scene.

22. At 4:46am, the fire was documented as *"well alight"* and *"not yet under control"*.

23. At 5:25am the fire was documented as under control and at 5:54am, the fire was extinguished.

24. UYB was found to have passed beside the recliner where he was sleeping.

25. NGN was found deceased in the kitchen, close to the open door leading to the lounge room. Beside him was a large torch and a fire extinguisher.

26. There was no evidence that a smoke alarm had sounded at any time during the fire.

Identity of the deceased

27. On 23 December 2022 UYB, born 2011, was identified via DNA comparison.

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

Medical cause of death

29. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine conducted an external examination on 21 December 2022 and provided a written report of his findings.

30. The examination showed findings consistent with the reported history.

31. Toxicological analysis of post-mortem samples detected carboxyhaemoglobin (**COHb**) at 29% saturation. COHb is a marker for carbon monoxide (**CO**) levels. The primary mechanism of CO toxicity is binding to the oxygen carrying part of the blood. Oxygen is then unable to bind and be carried around the body causing progressive hypoxia (lack of oxygen) and death. Adverse effects of CO include coma, confusion, headache, nausea, stupor, and weakness.

32. No other common drugs or poisons were detected.

33. Dr Lynch provided an opinion that the medical cause of death was *1(a) Effects of fire*.

34. I accept Dr Lynch's opinion.

FURTHER INVESTIGATIONS

Forensic Services Centre Report

35. Forensic Officers at the Victoria Police Forensic Services Centre attended the scene on 19 December 2022 and John Kelleher, scientist, provided a report of the findings. Other investigators from FRV also attended the same inspection.

36. Mr Kelleher noted that the pattern of damage over all the house indicated that the fire had started in the master bedroom.

37. He concluded that the cause of the fire was the ignition of combustible material in the master bedroom, probably near the head of the bed and approximately in the centre of the bed. The fire spread from the bed to the furniture, the adjoining ensuite bathroom, and walk-in robe before spreading to the lounge room and then into the main roof space.

38. There was a substantial amount of very thick glass melted and moulded into the springs of the bed which was thought to be the remains of an ashtray.

39. The report identified three possible ignition sources of the fire: a carelessly discarded or improperly extinguished cigarette butt, direct ignition, or an electrical fault or misuse of an appliance.

40. Direct ignition was considered unlikely as there were no multiple seats of fire, no flammable liquid, no fuel containers, and nothing else which might point to a directly ignited fire.

41. The report concluded that while no option could be definitively excluded, the most likely explanation was ignition by a cigarette butt.

42. The report also referred to UYB either not being aware of the fire or, if momentarily aware, was rapidly incapacitated as to be unable to escape the fire. It was noted that he may have been affected by carbon monoxide or smoke.

43. In relation to NGN, Mr Kelleher noted that he may have been in bed when alerted to the fire, given the damage to his right arm and sleeve. He appears to have attempted to extinguish the fire, including by going to the kitchen to obtain the fire extinguisher and torch, and likely suddenly became incapacitated.

44. I note that NGN's toxicology results showed ethanol (alcohol) at a concentration of 0.17g/100mL, COHb at 53% saturation, and small amount of diazepam and its metabolite nordiazepam. The combination of these drugs, COHb, and other effects of fire may have impaired NGN's cognitive function and reduced reaction times.

Fire Rescue Victoria Investigation Report

45. FRV completed a Fatal Fire Investigation report into the deaths. Investigators identified a single smoke detector in the main hallway. Further examination demonstrated that the smoke detector was more than 10 years old, the battery was no longer operational and had a printed use-by date of 2016.

46. FRV considered that the built environment was unlikely to have impacted the outcome of the fire.

47. FRV concluded that the fatal outcomes of the fire were preventable.

At-Risk Groups Report

48. Attached to the FRV report was a further report provided by the At-Risk Groups unit. The unit is part of the Community Resilience department within FRV and focuses on residential fire prevention and risk reduction for groups most at risk from fire in the home.

49. The At-Risk Groups report referred to the requirement that all residential properties must have working smoke alarms complying with Australian Standard *AS 3786:2014 Smoke alarms using scattered light, transmitted light or ionisation*[3] and that in owner occupied properties, the owner is responsible for ensuring that the smoke alarms are present and working.

50. The report went on to say:

> *'Smoke alarms have a lifespan of around 10 years, after which it is recommended by manufacturers that the smoke alarm is replaced. This is because the sensor may degrade over time. Australian Standard 3786:2014 requires that all smoke alarms have a recommended date of replacement legibly and indelibly marked on the alarm….However, it is commonly marked on the back of the alarm or inside of the casing and can be difficult to find. The difficulty in identifying the age of a smoke alarm and lack of awareness in the community about the limited lifespan of smoke alarms means that there may be large numbers of smoke alarms in Victorian homes that are over 10 years old.'*

51. The report recommended review and strengthening of existing smoke detector legislation in Victoria with specific comparison to Queensland legislation.

52. The report explained that following the Slacks Creek disaster in 2011, a house fire in Queensland which killed eleven people, the Queensland Government strengthened its smoke alarm legislation by mandating that by 2027, all smoke alarms in all homes regardless of when built must either be hardwired or powered by a non-removable 10-year battery, located in each bedroom and hallway on every level of a dwelling, be interconnected, and be less than 10 years old.

53. In comparison, the report explained that the requirements in Victoria for homes constructed after 1 August 1997 or homes which have undergone a major renovation, must have smoke

[3] An updated Australian Standard 3786:2023 has been published but there is no current requirement for smoke alarms already in place and compliant with Australian Standard 3786:2014 to be replaced to accord with the new standard.

alarms connected to mains power with battery backup. Homes constructed before 1 August 1997, such as the house in this case, may have battery-operated smoke alarms.

54. While not a legislated requirement in Victoria, FRV nonetheless recommends the additional requirements as contained in the Queensland legislation.

55. The report reiterated that key message of *"only working smoke alarms save lives"* and that the primary focus in a house fire is to alert others in the house, escape to a safe location, and call Triple Zero. This is because residential fires are fast and can rapidly escalate, producing toxic, super-heated smoke and flames that can become deadly within minutes.

56. The At-Risk Groups report also recommended that the coroner maintain a watching brief of fire related deaths with ignition caused by cigarettes. They noted the over-representation of smokers in residential fire fatalities and to smoking materials being a major source of ignition.

57. NGN's family provided a statement to the Coronial Investigator which stated that NGN smoked in the back pergola or occasionally in the loungeroom, but not in the bedroom. No one in the family recalled seeing a glass ashtray being used by NGN.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was UYB, born 2011;

    b) he passed on 19 December 2022 at Forest Road North, Lara, Victoria, 3212, from 1(a) effects of fire; and

    c) his passing occurred in the circumstances described above.

59. While investigators were unable to definitively exclude alternative sources of ignition, they were able to determine that the fire started on the bed. I am satisfied to the requisite standard that the source of the fire was a lit cigarette in the bedroom.

60. I also find that the smoke detector and alarm was not functional, and that this may have contributed to the deaths by preventing earlier warning of the fire.

61. I note FRV's comments about how quickly house fires can develop as well as witness statements about the intensity of the fire; I consider that by the time that fire fighters attended the scene, it was likely too late to save UYB and NGN.

62. I find that this was a tragic but preventable accident.

COMMENTS

Pursuant to section 67(3) of the Act I make the following comments:

1. The Coroners Court investigates multiple house fire related deaths each year. Many of these involve smoke detectors and alarms that have been inadequately maintained or otherwise rendered nonfunctional. I emphasise the message that *"only working smoke alarms save lives"*.

2. A copy of this finding will be provided to the Minister for Housing and Building with a recommendation to consider the suggestions made by Fire Rescue Victoria to strengthen smoke detector and alarm system requirements in Victoria.

3. Regrettably, it appears that stronger legislative requirements may not have made a difference in the circumstances of this matter, as it is apparent that the smoke alarm system which was in place was not compliant even with current requirements. What this case tragically highlights is a continued lack of public awareness that homeowners are responsible for having working and compliant smoke detector and alarm systems in place and of the critical role they play in providing early warning of a fire.

4. Nonetheless, it is important that steps be taken to continuously strengthen requirements as this simultaneously provides for improved safety and opportunities for increased awareness within the community of the risk that residential fires present. The increased public awareness and discussion associated with such changes, in addition to the changes themselves, may have prompted compliance in this case and prevented the deaths.

5. In addition to reviewing and updating smoke alarm legislation in relation to existing residences, this case also highlights the need for continued safety in the construction of new dwellings, such as the inclusion of sprinkler systems in all new residential buildings, regardless of height,[4] as supported by Fire & Rescue New South Wales. In their Fire Research Report, it was noted that sprinkler systems and smoke alarms in combination markedly

[4] Sprinkler systems are currently required in all buildings over 25 metres or 4 storeys or more, Specification 17, National Construction Code 2022, https://ncc.abcb.gov.au/editions/ncc-2022/adopted/volume-one/e-services-and-equipment/17-fire-sprinkler-systems

improve the safety of occupants in the event of a fire.[5] I note that consultation in relation to amending the National Construction Code to provide for sprinkler systems has been previously recommended to the responsible body, the Australian Building Codes Board, including by my colleague Coroner Olle in 2023[6] and more recently referred to by my colleague Coroner Giles in 2025[7].

6. The presence of a sprinkler system in conjunction with a working smoke alarm would afford occupants, including vulnerable members of our community, greater opportunity to escape and survive fires, lending weight to the call to consider:

   a. Strengthening smoke alarm requirements including mandating smoke alarms in every bedroom; and
   b. Mandating sprinkler fire systems in all new residences.

   While only new residences would provide this kind of 'double protection', in time, more people would benefit from such protection.

7. Many of the cases of fire related death also featured cigarettes as the likely ignition source and so I also reiterate the dangers of smoking inside, particularly in bed. This comment is equally applicable to hand rolled cigarettes which NGN reportedly smoked as it is to ready-made, manufactured cigarettes.

8. Finally, I reiterate the message that in the event of fire, the immediate priority should be the safe evacuation of self and others from the area, rather than fighting a fire. This case is an example of how quickly a fire can develop and the dangers of smoke inhalation.

RECOMMENDATION

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

i. That the Minister for Housing and Building consider and assess Fire Rescue Victoria's recommendation to strengthen smoke detector and alarm system requirements in Victoria along the lines of the reforms introduced in Queensland, including mandating that smoke alarms in all homes, regardless of when built, be either hardwired or powered by a non-

[5] 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
[6] COR 2020 003017
[7] COR 2022 006787 and COR 2022 006788

removable 10-year battery, be interconnected and less than 10 years old and to consult with Fire Rescue Victoria, the Country Fire Authority, the Victorian Building Authority and the responsible Queensland Minister in relation to the implementation of the legislative changes in that state. It is acknowledged that any mandatory changes to smoke alarm requirements may cause financial and other hardship to Victorian homeowners such that it is recommended that the Minister consider an appropriate lead time and support by way of rebates or discounts akin to that provided as part of the Victorian Energy Upgrades.

I have elected to publish this finding to contribute to the community's awareness of the risk and sometimes fatal and devastating impact of residential fires. A copy of the finding will be provided to a number of organisations involved in the continued discussions around residential fire risk, safety improvements and public information campaigns.

I convey my sincere condolences to UYB's family and acknowledge KDB's words that the loss of UYB has broken their hearts. I acknowledge the important role and brave efforts of the first responders to this incident and the assistance rendered by the passerby.

Pursuant to section 73(1A) of the Act, I order that a de-identified version of 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:

KDB, Senior Next of Kin, (C/- Arnold Thomas & Becker Lawyers)
VGB, Senior Next of Kin
Senior Sergeant Mark Guthrie, Coroner's Investigator
Victims of Crime Assistance Tribunal
The Hon. Nick Staikos, Minister for Housing and Building
Fire Rescue Victoria
Country Fire Authority
Australian Building Codes Board
Home Sprinkler Coalition Australia

Signature:

Coroner Dimitra Dubrow

Date: 19 May 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.