

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2012 0934

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of: DANIEL PAUL SHEEHY

Delivered On:	19 February 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank Victoria 3006
Hearing Dates:	26, 27 and 28 May 2014
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Mr T Hannebery on behalf of the family
Police Coronial Support Unit	Senior Sergeant J Brumby

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of DANIEL PAUL SHEEHY

AND having held an inquest in relation to this death on 26, 27 and 28 May 2014

at Melbourne

find that the identity of the deceased was DANIEL PAUL SHEEHY

born on 1 September 1993

and the death occurred on 14 March 2012

at 61 Hume Avenue, Melton South, Victoria 3338

from:

I (a) EFFECTS OF FIRE

in the following circumstances:

Background and personal circumstances

1. Daniel Sheehy (Daniel) was born on 1 September 1993. The Sheehy family resided in Sydenham, Victoria. During 1999, Daniel attended Sydenham Primary School until his mother, Ms Vicki Sheehy and siblings moved to a farm at Ballan during 2001.
2. Daniel commenced schooling at Ballan Primary School, and then enrolled at Mount Edgerton Primary School. During 2001, the family moved to the Melton area where Daniel attended Melton Primary School. During 2003, the family relocated to Hoppers Crossing where Daniel recommenced his education at Mossfield Primary School. During 2004, Daniel and his family moved back to the Melton area where Daniel continued his education at Bellbridge Primary School until he completed year 6. In 2006, Daniel commenced at Straughton College in Melton. During 2009, Daniel was moved from Straughton College and placed into an alternative learning program.
3. Throughout Daniel's education, he suffered behavioural problems, which were eventually diagnosed as ADHD. As a result of that diagnosis, Daniel was prescribed dexamphetamine by treating Doctors Lyndon Best and Kevin Dunn. During 2006 and 2008, Daniel required operations on both knees.
4. Whilst attending the alternative learning program, Daniel commenced a pre apprenticeship with a panel beating business in Laverton North, called 'Handbrake Turn'.

During the same year, Daniel moved to Mill Park with Ms Sheehy where he commenced work as a panel beater with her then partner.

5. During 2010, Daniel relocated to his father Mr Damien Sheehy's home at 61 Hume Avenue, Melton South. At this time, he commenced working with a family member painting houses and playing for the Melton Cricket Club. Throughout his childhood and teenage years, Daniel was an active player of cricket, football and netball.

Background – Incident prior to the fire

6. During early February 2012, Daniel was at a friend's home when he was approached by Gary Wright, Brodie Salnitro and James Simpson. It has been alleged Mr Wright placed a gun to Daniel's head, forced him into the boot of a vehicle, and then drove him to an unknown location. This incident was said to have taken place due to drug activity being conducted by Mr Wright.
7. On Monday 12 March 2012, Daniel informed his girlfriend, Ms Shayle Kelly, that Harley Turner had been threatening him, calling him a 'dog', as Mr Turner believed Daniel was talking to Mr Wright about him.
8. On the same day, Daniel told Mr Sheehy that Mr Turner had threatened to do a 'run through' of their house, and was going to come through the laundry door, as he knew the door lock was broken. After hearing this, Mr Sheehy looked in the laundry to find the door barricaded.
9. On the evening of Monday 12 March 2012, Daniel's brother, Jamie Sheehy, received a text message from Daniel stating, *'I'm at war'*. When Jamie asked with whom, Daniel replied *'Harley and that'*.
10. During the evening of Tuesday 13 March 2012, Daniel spoke to Ms Kelly on his mobile phone, with the call ending at 12.07am. No further calls were made from Daniel's phone after this time. Information obtained from Daniel's telephone records confirms this.
11. During this conversation, Daniel informed Ms Kelly that he was scared of Mr Turner. She suggested to Daniel that he sleep in his father's room, but Daniel stated that he wanted to stay in his own room in case people tried to enter via the front of the house.
12. The evidence of Mr Damien Sheehy was that he believed that his son genuinely feared a run through of their house, that an incident did take place which involved some form of foul play and that this caused or contributed to his son's death. The coroner's investigator investigated this issue thoroughly. He concluded that, although it was reasonable for

Daniel to expect a run through of the house on the night, and that Daniel was genuinely fearful for his own and his family's safety, he could find no evidence that foul play caused Daniel's death.

Circumstances of the fire and death

13. Daniel resided with his father and brother, Brock, at 61 Hume Avenue, Melton South. On the evening of 13 March 2012, it appears all members of the household were present and had gone to bed in their respective bedrooms. Daniel had a conversation with Ms Kelly, which commenced at approximately 11.15pm and lasted for about 45 minutes. Apart from a short exchange between Daniel and his father just after midnight, this would have been the last contact that anyone had with Daniel.
14. At around 1.40am on 14 March 2012, Mr Sheehy was awoken by loud noises and cries of his son, Daniel. He approached Daniel's bedroom and attempted to open the door, where a fire was raging. He was at first repelled by a backdraught, and opened the door again to attempt to pull his son from the blaze. The fire was fierce at that stage and, as a result, Mr Sheehy was unable to get his son out. He ran onto the street and called for assistance.
15. The first record of emergency services being called was at 1.41 am. Several neighbours attempted to assist in various ways and, in particular, a friend and neighbour, Mr Steven Kelly, tried to gain entry to Daniel's room, but was blocked. He then tried to gain entry to the bedroom through a window and observed a hole in the window about the size of a fist. Mr Kelly also observed that the awning in front of Daniel's window was down. Tragically, Daniel could not be rescued from the fire and died at the scene.
16. An autopsy of Daniel's body and post mortem CT scanning (PMCT) were performed by Senior Pathologist Dr Michael Burke of the Victorian Institute of Forensic Medicine, which revealed the cause of his death to be *effects of fire*.¹ Post mortem toxicological analysis revealed the presence of methylamphetamine, amphetamine, cannabis metabolite and methorphan in urine, and methorphan in blood. No Ethanol (alcohol), or other drugs were detected.
17. Dr Burke also noted a region of depressed fracture of the anterior aspect of the left tibia. Daniel's leg had become detached. Dr Burke's comments in his report are that it was probably a post mortem fracture. There was no evidence to suggest gunshot injury, and it

¹ Report of Dr Burke, Exhibit 13, inquest brief p 177.

was noted that Daniel's medical history included operations to both knees. (I will deal with this in detail later in these findings).

18. The investigation of the fire revealed no evidence of flammable liquid or accelerant being detected. Victoria Police Forensic Officer Ms Rachel Noble examined the scene and provided a report. Ms Noble concluded that the most likely source of ignition was a carelessly discarded or improperly extinguished cigarette. Ms Noble stated that a deliberate ignition could not be excluded, but there was no evidence to support that conclusion. (This will also be dealt with in detail later in these findings).
19. At the time of his death, Daniel felt that he was actively under threat by certain individuals.

Purpose of a Coronial Investigation

20. This finding is based on the totality of the material the product of the coronial investigation of Daniel's death. That is, the brief of evidence compiled by DLSC Pearce, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them. All of this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.
21. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or may be guilty of an offence.² However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if the coroner believes an indictable offence may have been committed in connection with the death.³

The Inquest

22. An inquest into Daniel's death was held between 26 and 28 May 2014. Time was given for further investigation and for final submissions to be made by legal representatives of the family. The closing date for those submissions was 17 November 2014 and no submission was received.
23. The following witnesses gave evidence at inquest:

² Section 69(1) *Coroners Act 2008* (Vic).

³ Sections 69(2) and 49(1).

- Mr Dirk Boyes
- Senior Constable Elizabeth Burke
- Dr Michael Burke
- Mr Gavin Gillies
- Ms Shayle Kelly
- Ms Rachel Noble
- Ms Natalie Parks
- Detective Leading Senior Constable Graeme Pearce
- Mr Brock Sheehy
- Mr Damien Sheehy
- Mr Harald Wrobel.

Scope of the Inquest

24. The principle focus at inquest was the cause of the fire. Another issue, covered in detail by Dr Burke, was the apparent physical impediment causing Daniel to be unable to escape from his burning bedroom.
25. A background issue concerned certain named individuals (referred to earlier in the summary) and whether they were in any way connected with Daniel's death.
26. There was also a question about whether I should call, and potentially compel, any of the named individuals to give evidence. DLSC Pearce was asked to further pursue those enquiries and advise of the outcome of the further investigation. He provided me with a statement dated 7 October 2014, in which he advised that he was unable to progress his investigations with any of the named individuals.
27. I have considered whether I should take steps to further investigate that issue. If the forensic evidence supported the proposition that the fire was caused or contributed to by a third party, or by any person involved in any form of foul play against any member of the Sheehy family, I would have taken further action to seek to compel evidence from the named individuals. However, the forensic evidence is to the effect that there was no foul play involved in the fire that caused Daniel's death.

Cause of the fire

28. 61 Hume Avenue is a single storey brick home with a tiled roof on the northeastern corner of Hume Avenue and Murray Street. The front door of the property opens west onto

Murray Street. The fire damage to the premises was mainly confined to the front bedroom – Daniel’s room. The adjacent kitchen and lounge areas were affected by smoke and heat.

29. Daniel’s bedroom was located at the southern end of the house, adjacent to the north of the front door. Inside this room was a double bed on the northeast side of the room, a double timber frame window with lace curtains and drapes, a cupboard and a chest of drawers in the area of this window, and a small two-seater couch against the southern wall next to the doorway.
30. The intensity of the fire caused total destruction to internal sections of the bedroom including the ceiling area. Furniture items inside the bedroom at the time provided an abundance of combustible material.
31. Daniel was located on his back just inside the doorway to his bedroom by Country Fire Authority (CFA) members. His head was facing to the west. Daniel had sustained severe fire damage to all extremities and the left leg had become detached near the knee. CFA members believed they had disturbed the body during fire suppression, which may have resulted in the post mortem injuries to Daniel’s leg.
32. Due to the extent of fire damage to the area of origin (bed), no appropriate samples for detection of possible presence of flammable liquid were obtained. A sample was collected from the floor near Daniel, with no flammable liquid being detected.
33. The post mortem examination revealed no gunshot damage or bruising to the lower legs. Victoria Police Forensic Officer Mr Harald Wrobel, who has extensive experience in the fields of electron microscopy and gunshot residue, also conducted examination of a bone sample. Mr Wrobel concluded that the examination did not reveal any signs of the area of the leg coming into contact with a fired bullet.
34. The key witness on the issue of the cause of the fire was Ms Noble, a scientist at the Victorian Police Forensic Services Centre. Ms Noble has extensive experience in fire investigation and I accept her credentials as an expert.
35. Ms Noble concluded that the fire damage to Daniel’s room was consistent with the ignition of the bed and bedding on the western end of the bed, particularly to the southern side of the bed, this area being the nominated point of origin of the fire. Burn patterns observed by Ms Noble were consistent with the fire burning on top of the bed then spreading to the contents under the bed. Ms Noble concluded that the most likely source of ignition was a carelessly discarded or improperly extinguished cigarette.

36. No other obvious sources of accidental ignition were identified in the probable area of origin of the fire. Whilst deliberate ignition could not be excluded, there was no evidence to support this.
37. Ms Noble stated that the southern bedroom had sustained the most fire damage, with moderate to heavy charring to the structure and the contents, especially the furnishings. The roof and ceiling had collapsed and plaster had fallen from the walls. The windows were broken and most of the glass on the ground outside was sooted and heat affected, with a small amount of clean broken glass, indicating that the window was intact or mostly intact at the time of the fire.
38. Ms Noble noted the remains of a chest of drawers in the southwestern corner, against the western wall and in the northwestern corner was a smaller chest of drawers. There was a bed frame and mattress in the northeastern corner and against the southern wall were the remains of an unidentified item of furniture. There was a built in wardrobe in the southeastern corner and inside the wardrobe was another small chest of drawers. Ms Noble noted that the bedroom door was closed at the time of the fire, and that Daniel's body was located on the floor behind the door, covered with debris from the roof and ceiling.
39. Daniel was found lying on his back, with his head by the furniture against the southern wall and his feet near the built in wardrobe. His left leg had become detached near the knee, during or after the fire. His tongue was protruding from his mouth, which suggested that he was alive at the time of the fire. Ms Noble noted no obvious remains of clothing on the body. Underneath Daniel's body were the remains of an aluminium baseball bat.
40. Samples of burnt debris were collected for further examination for the possible presence of flammable liquid, and no flammable liquid was detected. Ms Noble stated that this might mean that either there was no flammable liquid originally present, or that any flammable liquid had burnt or evaporated to below the detectable level.
41. Ms Noble stated that all of the power leads had insulation present or partially present, and that there was no evidence of an electrical event, such as arcing, having occurred. There was material still present on the mattress above the television, indicating the fire had not started underneath the bed or at the western end of the room.
42. The burn patterns were consistent with the fire burning on top of the bed and spreading to the contents under the bed; the underside of the mattress was still present along the northern side and eastern end. The western end of the bed, particularly the southern side

had sustained the most heat and fire damage. There was no material remaining on the top of the mattress and the fire had consumed the bedding. The remains of a cigarette lighter were found on the floor on the southern side of the bed, near Daniel's body. The lighter was collected and visually examined, however due to the extent of damage to the cigarette lighter, no further examination was feasible. There were no other areas in the house that were regarded as likely seats of fire.

43. Ms Noble concluded that the pattern and extent of fire damage were consistent with the fire starting in the southern bedroom, by the ignition of the bed or bedding, in the western half of the bed. There was no evidence to suggest that flammable liquid had been used to initiate or spread the fire, however the use of a small amount could not be excluded. No containers of the types commonly used to store or transport flammable liquid were identified among the debris.
44. Several witnesses stated that Daniel smoked cigarettes in his bedroom. Mr Sheehy gave evidence to that effect⁴ as did Ms Kelly and Dirk Boyes. Ms Kelly made a statement and gave evidence at inquest. She stated that Daniel would sometimes smoke inside and that if he did, it was in his bedroom. Ms Kelly had seen Daniel in bed smoking cigarettes and other substances. She was aware of Daniel using a 'jet lighter' but stated that he usually used an ordinary cigarette lighter, and did not use matches;⁵ Mr Boyes said that Daniel used cigarettes, marijuana and ice, and that he used what Mr Boyes called a jet lighter to smoke his ice pipe.⁶ Mr Boyes drew a picture of the lighter device used by Daniel and provided it to the police. The evidence of Ms Noble was that by the time the fire had consumed the bedroom, no remains of such a device could be found, even if it had been in the room before the fire. Whether a cigarette lighter or any other device (including the device referred to by Mr Boyes) was involved in contributing to the fire is an open question. However, on balance it appears not.⁷
45. Given this information and given the observations of the damage to the bed and the room, Ms Noble's opinion was that the most likely source of ignition was a carelessly discarded, or improperly extinguished cigarette. There were no other obvious source of accidental ignition identified in the probable area of fire origin.

⁴ Statement of Mr Damien Sheehy, Exhibit 1, inquest brief p 56.

⁵ Inquest transcript pp 59-60; 75-6.

⁶ Statement of Dirk Boyes, inquest brief p 83.

⁷ Statement of Ms Rachel Noble, inquest brief p 165.

46. The possibility or indeed probability that Daniel was smoking either methamphetamines or marijuana or both whilst sitting on his bed that night is strengthened by the toxicology result. It is also supported by the evidence of Brock Sheehy who said in his statement that he believed that Daniel might have used ice on the night of his death in order to stay awake *'in case people came for him'*.⁸
47. In her oral evidence, Ms Noble described the process of examining a fire scene. She said that in this case, it took quite a few hours and that it was a 'detailed and lengthy examination'.⁹ Ms Noble described finding the seat or source of the fire in the process of examination and described going through a process of elimination when examining a scene.¹⁰
48. In relation to fire being deliberately lit, Ms Noble's evidence was that from her experience examining fire scenes where they had been deliberately ignited using flammable liquids, different burn patterns would appear to what was observed at this scene.¹¹
49. In relation to evidence that Daniel using a jet lighter or torch type of device to smoke methamphetamines in a glass pipe,¹² Ms Noble stated that there was no such item identified in the debris and that, if it were located, she would have noted it as significant as a source of ignition present in the room.¹³
50. I accept Ms Noble's evidence, based on her extensive experience. I accept that in the absence of direct evidence of cigarettes being the source of ignition, it must remain open that there was another cause. There are still other possibilities, but I accept Ms Noble's evidence that they should be considered as *'unlikely in this case'*. It is clear that other possibilities can never be excluded 100 per cent as Ms Noble stated at inquest. Ultimately, I accept her hypothesis that the most likely cause of this fire was smoking in the bedroom, most likely on the bed.
51. On the question of the point of ignition of the fire considered to be on the bed, DLSC Pearce expressed the opinion that if an object had been thrown through the window to

⁸ Statement of Brock Sheehy, Exhibit 9, inquest brief p 91.

⁹ Inquest transcript p 212.

¹⁰ Ibid p 213.

¹¹ Ibid pp 213-5.

¹² Ibid p 216.

¹³ Ibid p 217.

- cause the fire, it would have hit the curtain, which was a heavy drape, and fallen to the floor at that part of the room. However, there was no evidence of that occurring.
52. DLSC Pearce reiterated in relation to this issue that there was nothing that positively indicated that any other person was involved. He was not able to establish any link between the threats to Daniel by various individuals, and the fire itself. I accept the interpretation put forward by the experts, that based on the available scientific and forensic evidence, the fire was caused accidentally.
53. In relation to the hole in the window of the bedroom, DLSC Pearce stated that he believed that it may have been caused by '*super heated gas*' and that it was a '*heat release point*',¹⁴ in his words. DLSC Pearce stated that he had seen it in every test fire, and expected to see a hole in glass in a situation such as this. Although he was not the arson expert in the case, this had a high degree of credibility about it.
54. Although there was no final formal submission on behalf of the family, I note that the family remain sceptical about the likely source of fire being a cigarette. Ms Noble considered it the '*most likely source*'. Ms Noble made it clear in her evidence that there was no evidence of any accelerants, but also noted that if there had been flammable liquids in the room (including within the cigarette lighters that were found), all had been consumed by the fire. Ms Noble was not able to describe the nature of the bedding materials, as they too have been consumed by the fire.
55. Mr Hannebery, on behalf of the family, cross examined DLSC Pearce and explored the alternative scenario: that another party was involved in Daniel's death. The fire took place on the very night Daniel was expecting a home invasion (an expectation considered reasonable by DLSC Pearce) against the background of threats. As Mr Hannebery put it, it is '*extraordinarily coincidental*'.¹⁵ Given the coincidence, DLSC Pearce was at pains to investigate the matter thoroughly and although deeply compassionate towards the family, he was forced on his assessment of the evidence to conclude that the fire was accidental. I accept that assessment.
56. DLSC Pearce accepted that there were persons who apparently wanted to harm Daniel and that some had violent tendencies. He observed that he did not think Daniel would be quiet in the face of an aggravated burglary or run through, even if he were expecting one.

¹⁴ Inquest transcript p 175.

¹⁵ Ibid p 182.

He made the point that the absence of any yelling before the fire, or at the point of it, suggested no confrontation between persons coming into the house and Daniel before the fire. I accept that as a reasonable interpretation.

The leg injuries

57. A troubling conundrum in the case remains – why was Daniel not able to stand up when his father went into the room to rescue him? Daniel said at the time that he could not stand, but the medical evidence indicates that he should have been able to do so.
58. In his report dated 11 July 2012, Dr Burke detailed his observations. Under the heading ‘Lower Limbs’, Dr Burke noted that the left leg was detached through the distal femur, with burning of the ends of the long bones, loss of all skin and fat and exposure of burnt underlying skeletal muscle. Dr Burke noted extensive burning of the anterior aspect of the left lower leg, and a probable post mortem fracture to the distal left tibia. Dr Burke also noted extensive burning and subcutaneous fat of the right leg with exposure of underlying burnt muscle and exposure of burnt distal femur, knee joint and the entire medial right tibia.¹⁶
59. Under the heading ‘Musculoskeletal System’, Dr Burke stated that deep dissection of the musculature to the lower limbs showed no suggestion of bullet track, and that the medial aspect of the tibia showed two depressed regions in areas of burnt but still robust bone. Dr Burke noted a ‘*punched in*’ bony defect extending 35cm above the heel. Dr Burke noted a fine fracture extending upwards towards the knee joint, within an area of markedly burnt bone, however he stated that the bone was quite robust at this point with no suggestion of post mortem destruction by fire. A further defect toward the medial upper aspect of the tibia was noted.¹⁷
60. Dr Burke concluded that the post mortem examination and PMCT showed no evidence of injury which would have led to death.
61. The possibility that Daniel suffered leg injuries prior to the commencement of the fire was investigated, with Dr Burke making serial incisions into the residual skeletal muscles of the lower legs. No bruising could be seen.
62. It was further suggested that there were allegations that a firearm may have been used in the incident prior to the fire. Dr Burke stated that close examination of the musculature

¹⁶ Report of Dr Burke, Exhibit 13, inquest brief p 177.

¹⁷ Ibid p 176.

showed no projectiles or wound track, and PMCT revealed no metallic material. Dr Burke stated that *it would appear very, very unlikely that a gunshot injury to the tibia would occur without deposition of some metallic material to the wound.*¹⁸

63. Dr Burke considered the toxicology report and noted that there was no carbon monoxide (carboxyhaemoglobin) detected. He stated that this is unusual in a house-type fire where fires tend to be associated with considerable smoke. However, Dr Burke noted that soot was found within the airway, indicating movement of air within the airway prior to death from the fire.¹⁹
64. When asked if Daniel had been shot in the legs, Dr Burke explained that every deceased person whose death is reported to the coroner is subject to a CT scan, so that if a person had been shot to the leg with the bone being hit, damage to the bone and fragments of metal would be observed. Dr Burke noted no metal but explained the possibility that a projectile could have gone through soft tissues and involved major arteries or nerves, but that it was not obvious in this case because the skin had been burnt away. Dr Burke therefore made serial incisions into muscle all the way down the leg looking for a wound to track, and did not see one. His opinion based on that examination was that Daniel had not been shot in the leg.²⁰
65. Dr Burke detailed two injuries to Daniel's left leg, both to the left tibia. He concluded that the injuries were sustained post mortem.²¹ One injury was just below the knee and the other was closer to the ankle. At inquest, he dealt with this issue in greater detail. Dr Burke described the left leg as '*detached*', meaning that it was separated through the distal femur, the major thigh bone. He described loss of all skin and fat and exposure of significantly burnt underlying bone, and noted a probable post mortem fracture to the distal left tibia eight centimetres from the ankle joint. At inquest, Dr Burke stated that the evidence of CFA officers disturbing the scene could explain that injury. He emphasised that the injury occurred to a very burnt and brittle area.
66. Dr Burke agreed that the force of falling material from a roofing height could explain the fracture to the front of the leg. Asked if that particular injury would have been prevented

¹⁸ Report of Dr Burke, Exhibit 13, inquest brief p 177.

¹⁹ Ibid pp 177-8.

²⁰ Inquest transcript pp 157-8.

²¹ Ibid pp 159-60.

Daniel from walking, Dr Burke responded that the injury would be quite painful, but would not of itself stop a person from walking.²²

67. Dr Burke was cross-examined on his hypotheses. He noted that the fire damage to the body made it difficult to be definitive, but on balance believed one injury may have been caused by a falling tile and the other by fire fighters walking in the fire scene on the brittle bones of the then burnt body. He described these types of post fire brittle bone fractures as '*not uncommon*'. As a matter of complete fairness, Dr Burke conceded that he could not completely exclude alternative explanations for the two leg injuries. I accept Dr Burke's evidence.
68. The question remains as to why Daniel was unable to get up to try to get out of the room. In light of Dr Burke's evidence it remains impossible to definitively explain why Daniel could not get to his feet and walk. There could be a number of explanations, particularly given that his bedroom was at the time the subject of an intense fire. However, on the evidence it is not possible to reach a firm conclusion on this issue.

Previous threats to Daniel

69. As indicated earlier, I requested further investigation by DLSC Pearce in respect of the following persons – Gary Wright, Brodie Salnitro, James Butler and Samuel Jackson. DLSC Pearce checked the whereabouts of each person on the evening of 13 and 14 March 2012. LEAP checks reveal that Mr Butler was in custody, and that Mr Wright, Mr Salnitro and Mr Jackson were free in the community. DLSC Pearce detailed his attempts to contact Mr Wright, Mr Salnitro and Mr Jackson. He was able to confirm that Mr Butler was in custody and was informed by Mr Butler that Mr Wright and Mr Salnitro had both stated that they were not involved in Daniel's death. DLSC Pearce made contact with solicitors acting for Mr Wright and Mr Salnitro in a recent trial. This did not lead to any further productive contact.
70. In his statement, DLSC Pearce said that making contact with these persons had proven difficult and left him in no doubt whatsoever that they did not wish to assist in any manner.²³ I accept this assessment. However, what matters is whether there is, on the evidence, any connection between these individuals and the fire that caused Daniel's death. On the objective and scientific evidence, there is no such connection. In the

²² Inquest transcript pp 162-3.

²³ Statement of DLSC Pearce dated 7 October 2014.

absence of evidence of some involvement in Daniel's death, it is not necessary or appropriate to take the investigation of these individuals any further.

71. If the scientific and forensic evidence indicated the involvement of a third party or any form of foul play, it would be a different matter. If it did, I would take steps to have these individuals called, and if necessary compel them to give evidence. As DLSC Pearce conceded, and as the family has emphasised, there is a coincidence between the accidental fire killing Daniel, and the threat that on the very night this happened, there would be a 'run' through of the house in which Daniel, his father and brother lived. I fully appreciate that it is difficult for the family to accept, but on the evidence it was, in fact, a coincidence.

Evidence of Mr Damien Sheehy

72. Mr Sheehy stated that he went to bed at about 11.00pm on Tuesday 13 March 2012 and that Daniel was out a short time before this, but returned home just before he went to bed. Mr Sheehy asked if he was okay and they had a general conversation.
73. Mr Sheehy stated that at about 2.00am on 14 March, he woke to hear loud banging sounds, and Daniel screaming for help. He ran to Daniel's room and saw the door closed. He opened it and saw that fire had engulfed the room. Mr Sheehy stated that he yelled to Daniel to get up, and that Daniel gave Mr Sheehy his hand but that Mr Sheehy could not pull him out and that Daniel was unable to get up. The door then closed and Mr Sheehy pushed it open again but stated that it became too hot and that the flames took over the room. Mr Sheehy yelled to Daniel to get out, but the flames worsened and Mr Sheehy could do nothing more.²⁴
74. Mr Sheehy made two statements, gave oral evidence at inquest and wrote to the Court twice. Mr Sheehy believed at the time of Daniel's death, and continued to believe during and after the inquest that his son had been murdered. Understandably, he felt a deep sense of anguish about the fact that he had not been able to save his son's life. He tried hard to do so but was defeated by the fire.
75. Mr Sheehy was particularly upset about the fact that his son had spoken to him before he went to bed that night and asked him not to go into his room. His evidence was that:

...he came into my room and as calmly as we're talking now he said, "Dad, no matter what happens tonight - " and then if I say he went on the "rev limit" like

²⁴ Statement of Mr Damien Sheehy, Exhibit 1, inquest brief p 55.

*he's screaming, and he stressed, "Do not come into my room." And because I'd had sleeping tablets that night, I just thought, oh, yeah, you know, he's just a bit fired up, you know, I didn't take a lot of it - pay a lot of attention to it.*²⁵

76. Mr Sheehy's evidence was that when he went into the room to try to rescue his son, the first time the door shut back on him, and the second time when he did get into the room, he saw Daniel kneeling on the floor. He emphasised that Daniel appeared to be kneeling as if he were praying at the end of his bed.²⁶
77. It is quite clear that Mr Sheehy tried to save his son's life. I accept the evidence he gave about the attempts he made and what happened when he made them. I accept that when Mr Sheehy tried to get into the room the first time he was forced back and that on the second occasion, he was able to grab hold of Daniel but unable to move him from the room.
78. On the evidence, it appears that Daniel was in fact unable to get to his feet, or for some inexplicable reason did not try to do so. It is also clear on evidence, including the evidence of observers, that the fire in the bedroom was intense and that to rescue a person in the middle of it, unable to move under their own steam, would be very difficult. It appears also that the bedroom door was an obstacle in helping Daniel out. There was a question whether the operations on Daniel's knees during his teenage years might have had some bearing on whether he could or could not move during the fire. Mr Sheehy's evidence was that Daniel was very active and had had two knee arthroscopy procedures, but that he did not have difficulty walking after the procedures and was described by Mr Sheehy as '*an athlete*'.²⁷ There is no basis on which to conclude that the arthroscopies earlier in Daniel's life would have affected him on the night of the fire.
79. I note Mr Sheehy's letters to the Court dated 3 June and 24 November 2014, on behalf of the Sheehy family. In both letters, Mr Sheehy urges me to find that Daniel's death was due to homicide, and points to evidence that, in the family's view, enables me to make that conclusion. The letters reveal a loving family understandably consumed by grief and searching for answers. I have carefully considered the contents of the letters, but must make my findings based on the totality of the evidence. On that evidence there is no objective reason to conclude that Daniel's death was due to foul play.

²⁵ Inquest transcript p 10.

²⁶ Ibid p 11.

²⁷ Ibid pp 42-3.

Evidence of Steven Kelly

80. Another person who tried to save Daniel during the fire was his neighbour Mr Steven Kelly. Mr Kelly described seeing an orange glow coming from the Sheehy home at about 2.00am. He thought Mr Sheehy was yelling '*help me*' and '*my boy, my boy*'.²⁸ Mr Kelly described running over to the house and through the front door, and kicking the bedroom door with the door opening a little and springing back like '*something was blocking it from behind*'.²⁹
81. Mr Kelly said that he did not know if Daniel was in the room, and that he was screaming for Daniel. He said he did not hear anything from inside the room to make him believe anyone was in there. He could not get the door open, so he ran outside to see if he could get through the bedroom window. Mr Kelly described the awning covering Daniel's bedroom window (also described by Mr Sheehy). It was pulled all the way down at the time and Mr Kelly described grabbing it to try to move it out of his way, but said that it all came down in his hands. He said that he saw the hole in the window and that he broke the window with the hole in it using the awning to try to get to Daniel. As he did, the flames '*shot out the window and pushed [him] back*'.³⁰ Mr Kelly stated that he did not see where Daniel was at that stage, and was still unsure if he was in the room. Mr Kelly decided to extinguish the fire with a nearby hose. He turned the hose on and got as close as he could without being burnt.
82. I commend Mr Kelly for his courageous attempts to save Daniel and for doing all that he could in the circumstances.

Conclusion

83. I find that Daniel Sheehy died from the effects of fire as a result of an accidental fire, the precise cause of which cannot be determined but which is likely to have started on his bed in his bedroom on the night. On the evidence, no other persons were involved in his death.

I extend my condolences to the family and friends of Daniel Sheehy.

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

Mr Damien Sheehy

²⁸ Statement of Mr Steven Kelly, inquest brief p 73.

²⁹ Ibid p 73.

³⁰ Ibid p 74.

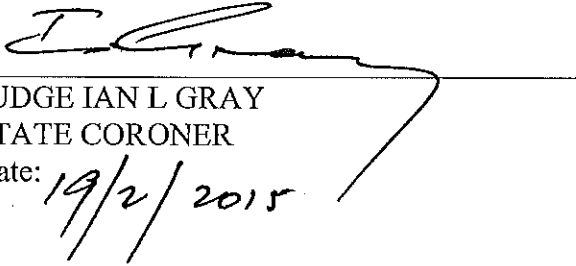
Ms Vicky Sheehy

Mr Tony Hannebery, Tony Hannebery Lawyers

DLSC Graeme Pearce, Victoria Police, Coroner's Investigator

S/Sgt Jen Brumby, Police Coronial Support Unit.

Signature:



JUDGE IAN L GRAY
STATE CORONER
Date: 19/2/2015

