IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004111

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Ya (Cindy) Zhao
Date of birth:	27 January 1994
Date of death:	22 July 2022
Cause of death:	1(a) EFFECTS OF FIRE
Place of death:	The Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3050

INTRODUCTION

1. On 22 July 2022, Ya (Cindy) Zhao was 28 years old when she died in a fire in her residential unit at 4/18 May Street, Doncaster East, Victoria.

THE CORONIAL INVESTIGATION

2. Ya'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 an officer to be the Coroner's Investigator for the investigation of Ya'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 Ya's death, including all 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.

7. In considering the issues associated with this finding, I have been mindful of Ya's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

8. Ya was born in China and migrated to Melbourne with her parents when she was eight years old. Although she made a successful transition into local primary school and excelled in her first year of high school, she started having mental health difficulties in late 2007 and early 2008 as she entered her second year of high school. Ya's parents noticed her losing confidence and becoming withdrawn, and attributed the change in her behaviour to a combination of being the victim of bullying, placing very high expectations on herself and relationship difficulties. By the end of 2008, Ya's mental health declined to the point where she stopped going to school. She also stopped socialising with friends, playing the piano and her usual sports activities. She was hospitalised for depression several times in the period 2009 to 2013 and eventually diagnosed with schizophrenia.[2] She received a disability pension and never worked.[3]

9. In 2015, Ya's health improved after returning from a family holiday in China, and she resumed playing the piano. She continued to improve and by 2018 she said she was ready to live by herself, so her parents helped her move into the family's unit in May Street, Doncaster East. She remained supported by Eastern Health as an outpatient, although these services were significantly disrupted during the COVID-19 pandemic.[4]

10. Ya's mental health again declined and on 17 February 2021 she required a home attendance by the Eastern Health Crisis Assessment and Treatment (**CAT**) team. Whilst the team were discussing her treatment plan with her parents outside, Ya lit a small fire on her doona in her bedroom, which was noticed by her mother and quickly extinguished.[5] She refused to engage with the CAT team or her parents about this behaviour and was taken by ambulance to Box Hill Hospital, where she stayed as a patient at Upton House for approximately two months before she was discharged home. Her health fluctuated from that time onward. There had been

[2] Statement of Dr Xiong Tan, Coronial Brief, sets out the family history.
[3] Statement of Zongjin Zhao, Coronial Brief.
[4] Statement of Zongjin Zhao, Coronial Brief.
[5] Statement of Zongjin Zhao, Coronial Brief.

earlier incidents of self-harm and suicidal ideation whilst she was experiencing psychotic episodes.[6]

11. On Wednesday 20 July 2022 at 3:43 am emergency services were called to a fire at Ya's unit[7] after being alerted by a neighbour.[8] At 3:50 am, Fire Rescue Victoria (FRV) personnel arrived at the scene and commenced extinguishing the fire.[9]

12. During their initial search of the property an unresponsive person (now known to be Ya) was located on the loungeroom floor and rescued though an adjacent window.[10] At 4:05 am, Ambulance Victoria personnel attended and commenced resuscitation attempts.[11]

13. Although Ya never recovered consciousness,[12] she was transported to the Royal Melbourne Hospital and placed on life support. On Saturday 23 July 2022, after discussion with her family, Ya's life support was switched off and she passed away at 4:12 pm.[13]

Police investigations

14. Police identified no suspicious circumstances surrounding the fire.[14] Ya's unit was a brick veneer three-bedroom structure. It was one of four units on a medium sized residential block. Police Forensic Officer John Kelleher examined the scene and concluded the fire had originated in Ya 's bedroom, where the extremely damaged remains of a laptop computer were found on the western side of the double bed. Independent forensic fire scene investigator Phil Glover also attended the scene and concurred that the remains of the electrical components found intertwined with the remains of the mattress structure appeared to indicate a "strong possibility" that overheating and ignition of a lithium battery within that electrical device was the cause of this fire.[15] Ya's father explained that there was not a television in the house, and that Ya used her laptop to view media.[16]

[6] Statement of Dr Neena Sharma, Coronial Brief.
[7] Statement of Mark Power, Coronial Brief.
[8] Statement of Rebecca Chin, Coronial Brief.
[9] Statement of Mark Power, Coronial Brief.
[10] Statement of Mark Power, Coronial Brief.
[11] Statement of Chris Hastings, Coronial Brief.
[12] Statement of Dr Yasmine Abdelhamid, Coronial Brief.
[13] Statement of Dr Yasmine Abdelhamid, Coronial Brief; E-Medical Deposition of Dr Bridget King dated 23 July 2022.
[14] Statement of Glenn Evans, Coronial Brief.
[15] Statement of Phil Glover, Coronial Brief.
[16] Statement of Zongjin Zhao, Coronial Brief.

15. There were no indicators of the presence of any significant quantity of flammable liquid, and no suspicious odours. There was no evidence of smoking around the house and no lighter, matchbox or similar ignition source.[17]

16. There was a patch of unsooted carpet near the loungeroom window through which firefighters gained access to the apartment. This indicated Ya had been on the floor at a relatively early stage of the fire, before the loungeroom was completely filled with smoke. There was nothing to indicate an attempt to exit via the loungeroom window, and no signs of firefighting efforts by Ya, although these may have been obscured by subsequent damage.[18]

17. Ya's mother said that whilst her mood had not been good the day before the fire, the day prior to that she had been happy, though tired, during their regular church attendance.[19]

Identity of the deceased

18. On 23 July 2023, Ya (Cindy) Zhao, born 27 January 1994, was visually identified by her father, Zongjin Zhao.

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

Medical cause of death

20. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine conducted an external examination on 26 July 2022 and provided a written report of his findings dated 5 January 2023.

21. Toxicological analysis of ante-mortem blood samples collected at the time of Ya's admission to the Royal Melbourne Hospital indicated a carboxyhaemoglobin[20] saturation of 37%. Dr de Boer explained that this level of carboxyhaemoglobin can be considered life threatening. The medications amisulpride, clonazepam and metoprolol were also detected, albeit not in significant concentrations.

22. The findings upon examination of Ya's body were otherwise consistent with the known history.

[17] Statement of John Kelleher, Coronial Brief.
[18] Statement of John Kelleher, Coronial Brief.
[19] Statement of Zongjin Zhao, Coronial Brief.
[20] The complex formed within red blood cells when haemoglobin is exposed to carbon monoxide. Carbon monoxide is a colourless and odourless gas produced by the incomplete combustion of organic fuels.

23. Dr de Boer provided an opinion that the medical cause of death was 1 (a) EFFECTS OF FIRE.

24. I accept Dr de Boer's opinion.

FINDINGS AND CONCLUSION

25. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[21] Adverse findings or comments against individuals are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Ya (Cindy) Zhao, born 27 January 1994;

    b) the death occurred on 22 July 2022 at The Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3050, from EFFECTS OF FIRE; and

    c) the death occurred in the circumstances described above.

27. Having considered all of the circumstances, I am satisfied that her death was the unintended consequence of an accidental ignition in her bedroom, although I cannot be satisfied to the *Briginshaw* standard as to whether the ignition came from the laptop, a mobile phone, the battery of either, or some other source.

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

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

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

[21] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

Zongjin & Limni Wang Zhao, Senior Next of Kin

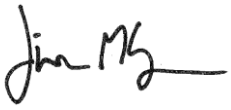
Christopher MacIsaac, Melbourne Health

Paul Katz, Eastern Health

Kellie Gumm, Royal Melbourne Hospital Trauma Service

Leading Senior Constable Glenn Evans, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 10 January 2024

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.