IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003044

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	John O'Grady
Date of birth:	21 May 1962
Date of death:	2 June 2025
Cause of death:	1a : EFFECTS OF FIRE
Place of death:	5/11 Bishop Street Box Hill Victoria 3128
Keywords:	Fire death;

INTRODUCTION

1. On 2 June 2025, John O'Grady was 63 years old when he was found deceased in his home. At the time of his death, John lived alone at 5/11 Bishop Street, Box Hill, Victoria, 3128.

2. John was born in England and moved to Australia with his family at the age of six. John grew up in Perth where he completed high school studies before completed tertiary studies in applied mathematics and ancient history. John was employed as a senior systems analyst before he discontinued working in 1997 due to the effects of Crohn's Disease.

3. John's last treating General Practitioner, Dr Beng Eu, confirmed that John was being treated for Bipolar Disorder, Crohn's Disease, Attention Deficit Hyperactivity Disorder (**ADHD**) and HIV.[1] John's Bipolar Disorder was being treated with an anti-psychotic medication in the form of Risperidone and his ADHD was treated with Methylphenidate under the guidance of a psychiatrist, Dr Diane Grocott.

4. John was last treated at the adult mental health inpatient unit in Box Hill hospital on 16 May 2025 when he self-presented after reporting that he had ceased using his risperidone medication, John was admitted for treatment and released on 28 May 2025.[2]

THE CORONIAL INVESTIGATION

5. John'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.

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

[1] *Coronial Brief*, Statement of Dr Beng Eu.
[2] *Coronial Brief*, Statement of Francis O'Grady.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned Senior Constable Emma Spunt to be the Coronial Investigator for the investigation of John's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of John O'Grady 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.[3]

10. In considering the issues associated with this finding, I have been mindful of John'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

11. On 2 June 2025 at around 7:45 pm, Mr Pinnaduwage Silva was reversing his car into his driveway at 14 Bishop Street, Box Hill, when he observed a bright light from the second level of the apartment complex at 11 Bishop Street.[4] After parking his car, Mr Silva walked across the road and heard windows cracking and that it appeared to be a fire. Mr Silva contacted emergency services to report the fire.

12. Fire Rescue Victoria (**FRV**) members arrived on scene at around 7:53 pm and located John's body, removing the body from the unit to a nearby hallway whilst attempting to get the fire under control. Ambulance paramedics arrived at 8:16 and confirmed that there were no signs of life from John's body and verified his death.[5]

13. At around 8:05 pm, Victoria Police arrived on scene and established a crime scene once the fire was fully extinguished. Police investigators assisted FRV investigators to assess the scene

[3] 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.

[4] *Coronial Brief*, Statement of Pinnaduwage Silva.

[5] *Coronial Brief,* Statement of Ambulance Paramedic Josephine Downey.

and there were no suspicious circumstances noted in relation to circumstances of John's death.[6]

Identity of the deceased

14. On 10 June 2025, John O'Grady, born 21 May 1962, was identified via DNA comparison.

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

Medical cause of death

16. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 4 June 2025 and provided a written report of his findings dated 22 September 2025.

17. The post-mortem examination revealed evidence of extensive thermal injury throughout the body, patchy coronary calcification, intact larynx but no bony trauma or intracranial haemorrhage.

18. Toxicological analysis of post-mortem samples identified the presence of ethanol (~0.26 g/100 mL), diazepam (~0.09 mg/L), nordiazepam (~0.2 mg/L), risperidone (~11 ng/mL), hydroxyrisperidone (~8 ng/ mL) and methylphenidate (~0.02 mg/L).

19. Dr Lynch noted that carboxyhaemoglobin and cyanide were not detected at elevated levels and there are a variety of noxious chemicals produced in fires that will not be identified in toxicological testing. Dr Lynch was of the view that it is also possible that John suffered a medical event around the time of the fire and that the extensive thermal injury to the body was sustained in the peri-mortem period.

20. Dr Lynch provided an opinion that the medical cause of death was 1(a) EFFECTS OF FIRE and I accept his opinion.

FURTHER INVESTIGATIONS

21. FRV investigators undertook a substantive investigation into the causes of the fire at 5/11 Bishop Street, Box Hill and provided me with a report noting the following:[7]

[6] *Coronial Brief*, Statement of Drective Senior Constable Adam Stafford.
[7] *Coronial Brief*, Exhibit 6 – Fatal Fire Investigation Report by Mark Hill dated 7 July 2025

a) There was substantive evidence of unsafe smoking inside John's dwelling, including in bed; with many discarded cigarette butts observed throughout the dwelling.

b) John was the sole owner and occupier of his unit which did not have a smoke alarm installed inside the property.

c) Internal aspects of the John's dwelling were affected by significant hoarding; egress pathways were partially obstructed.

FINDINGS AND CONCLUSION

22. 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.[8] Adverse findings or comments against individuals in their professional capacity, or against institutions, 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.

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

a) the identity of the deceased was John O'Grady, born 21 May 1962;

b) the death occurred on 2 June 2025 at 5/11 Bishop Street, Box Hill, Victoria, 3128, from 1(a) EFFECTS OF FIRE; and

c) the death occurred in the circumstances described above.

24. Having considered all of the circumstances, I am satisfied that John's death was the unintended consequence of the effects of fire which was likely caused by ignition from a cigarette butt discarded or dropped by John whilst smoking in bed.

COMMENTS

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

[8] *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…'.

25. In Australia, smokers are over-represented in residential fire fatalities and since 2020, Fire Rescue Victoria has identified at least 42 preventable residential fire fatalities that may have been caused by cigarettes.[9] This investigation highlights the dangers of unsafe smoking behaviours; those behaviours that lead to an increased risk of starting a fire with a cigarette. Unsafe smoking behaviours include smoking inside, particularly in bed, improper or unsafe disposal of cigarette butts or other smoking materials, and smoking while affected by alcohol, medications, or other drugs.

26. The available evidence confirms that John's dwelling did not have a smoke alarm. Working smoke alarms save lives by providing an early warning that a fire has started and provide a window of opportunity for occupants to escape before fire conditions become untenable. I confirm that by law, all residential properties must have working smoke alarms that comply with applicable Australian Standards.

27. I further note that there was evidence of substantial hoarding in John's dwelling. Hoarding behaviour is the persistent accumulation of, and lack of ability to relinquish large numbers of objects or living animals, resulting in extreme clutter in or around premises. This behaviour compromises the intended use of premises and threatens the health and safety of occupants, animals and neighbours. In this case, the level of hoarding and clutter restricted access and egress, whilst the number of stored items increased the fuel load, as well as amplifying the fire ignition.

RECOMMENDATIONS

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

(i) That the **Victorian Government** consults with Fire Rescue Victoria and Country Fire Authority to update smoke alarm requirements within regulations in the Victorian Building Act; and

(ii) That the **Victorian Government** reconvene the Hoarding and Squalor Taskforce to explore how agencies across various sectors may be able to further coordinate their efforts to reduce risk for people affected by hoarding or environmental neglect; determine what advice and

[9] *Coronial Brief*, Exhibit 6 – Fatal Fire Investigation Report by Mark Hill dated 7 July 2025.

support agencies may be able to provide to family members or other people supporting people who hoard to live more safely in their homes.

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

Pursuant to section 73(1A) 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:

Mr Frank O'Grady & Mrs Janet Veronica O'Grady, Senior Next of Kin

Jacques Claassen, Eastern Health

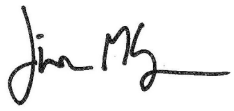
Dimitra Menon, CHU insurance

Bradley Fogden, Fire Rescue Victoria

Hon Jacinta Allen MP, Victorian Premier

Senior Constable Emma Spunt, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 16 March 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.