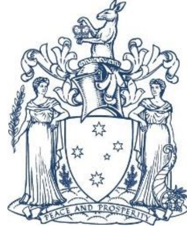

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003591

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Judith Ann Johns
Date of birth:	15 June 1961
Date of death:	3 July 2023
Cause of death:	1(a) Effects of fire
Place of death:	63 Upper Skene Street, Newtown, Victoria, 3220
Keywords:	House fire, hoarding

INTRODUCTION

1. On 3 July 2023, Judith Ann Johns was 62 years old when she died in a fire at her home at 63 Upper Skene Street, Newtown, Victoria.

2. Judith was born in Ballarat the youngest of three siblings to parents John and Margaret Stronach. Her older brother, born in 1956, sadly passed away shortly after his birth and predeceased Judith. Judith is survived by her older sister, Jillian, with whom she enjoyed a close and supportive relationship. In 1964, the family moved to Geelong as a result of her father's work. Judith completed a teaching degree at Deakin University and then worked in primary school and early childhood education until the birth of her son, Henry, in 1997.[1]

3. After Henry's birth, Judith suffered from post-natal depression and was ultimately diagnosed with bipolar disorder. Following an inpatient admission for psychiatric care, she was prescribed medication to manage the bipolar disorder, which she took regularly. Judith and Henry moved into 63 Upper Skene Street, Newtown when Henry was approximately three years old, and Judith was able to take care of herself and Henry with support from family.[2]

4. Judith received a disability support pension and earned additional income by purchasing and reselling clothing and accessories online. This venture led to an accumulation of items throughout the house. The stockpiling of items became gradually worse, until reaching the point where family could no longer visit. Apart from this hoarding, her mental health was well managed. She took care of her appearance, enjoyed cooking and maintained an active social life with friends and family.[3]

5. On Friday 30 June 2023, Judith visited her sister's home and dropped off some food for her because she was ill. From a text message exchange later the same day, she seemed to Jillian to be in good spirits.[4]

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[1] Statement of Jillian Crompton, Coronial Brief.
[2] Ibid.
[3] Ibid.
[4] Ibid.

THE CORONIAL INVESTIGATION

6. Judith'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.

7. 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.

8. 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.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Judith's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, eyewitnesses, the forensic pathologist, treating clinicians and fire investigation experts – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Judith Ann Johns 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.[5]

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

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[5] 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.

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

Circumstances in which the death occurred

12. Judith's home at 63 Upper Skene Street, Newtown was a single-storey, three-bedroom weatherboard residential house, with no smoke detectors.[6]

13. On Monday 3 July 2023 at approximately 2:00 am, Judith was home alone. One of Judith's neighbours, John Maguire, heard a 'strange crackling sound' from the upstairs of his home across the road. When he went downstairs and opened his front door, he saw that Judith's home was on fire. As he came back inside, he told his daughter to call 000, which she immediately did, then he grabbed some shoes and a torch so he could assist.[7]

14. The incident was captured on CCTV footage from Mr Maguire's doorbell camera. Another neighbour managed to record the fire from a bedroom window while his father, Tim Farrow, also went to assist.[8]

15. Mr Farrow started to make his way to the rear yard of Judith's property, but observed that a shed and the back portion of the house was already fully engulfed in flames. He was unable to proceed any further due to extreme heat, so returned to the front of the house, before working his way around the western side of the house, checking to see if any windows were able to be accessed. Returning to the front of the house, he first banged on windows and the front door, calling out to try to raise any occupants, then commenced attempting to break the front door open.[9]

16. Mr Maguire arrived at the front door just as Mr Farrow managed to kick the latch open. The house was full of thick smoke, and impossible to safely enter. The men were joined by Mr Maguire's daughter, who was still on the phone to emergency services. The three continued to try and raise any occupants until Fire Rescue Victoria arrived.

17. The attending fire units commenced attacking the fire from the rear of the property,[10] but once Senior Leading Firefighter Brady Trotter and Leading Firefighter Marcus Smith became

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[6] Statement of John Kelleher, Coronial Brief.
[7] Statement of John & Jessica Maguire, Coronial Brief.
[8] Statements of Tim & Archibald Farrow, and Exhibits 1 & 2, Coronial Brief.
[9] Statement of Tim Farrow, Coronial Brief.
[10] Statement of Tom Waterson, Coronial Brief.

aware that an occupant of the residence was not accounted for,[11] they entered through the open front door and commenced searching the bedrooms, where they had to contend with significant clutter in addition to the effects of the raging fire.[12]

18. As the remaining firefighting effort successfully proceeded from the rear of the house up towards the kitchen, Trotter and Smith were able to gain access to that part of the house and found Judith's body on the kitchen floor, clearly deceased.[13]

19. Arson Chemist John Kelleher from the Victoria Police Forensic Services Centre carefully examined the scene and did not identify any suspicious circumstances. He concluded the fire originated in the kitchen after the remanent stove top was found to be in the 'on' position, in conjunction with a badly burnt cooking pot found in that spot. No other accelerants or obvious ignition sources were identified.[14]

20. Judith's sister subsequently confirmed to my investigator that she had a habit of cooking late at night.[15]

Identity of the deceased

21. On 7 July 2023, Judith Ann Johns, born 15 June 1961, was identified via an expert odonatological comparison. Identity is not in dispute and requires no further investigation.

Medical cause of death

22. Forensic Pathologist Dr Michael Duffy from the Victorian Institute of Forensic Medicine conducted an autopsy on 10 July 2023 and provided a written report of his findings dated 25 September 2023.

23. Toxicological analysis of post-mortem blood samples identified the presence of alcohol at a potentially moderately impairing level of 0.08 g/100mL. Carboxyhaemoglobin was also detected at an elevated saturation of ~ 33%.[16] This, in combination with Dr Duffy's findings of soot in the airways, demonstrates that Judith inhaled smoke and was still alive when the

[11] Senior Station Officer Tom Waterson had the presence of mind to deduce under time pressure that if there was a car in the driveway, the occupant was likely to be home: statement of Marcus Smith, Coronial Brief.
[12] Statement of Brady Trotter & Marcus Smith, Coronial Brief.
[13] Statement of Brady Trotter & Marcus Smith, Coronial Brief.
[14] Statement of John Kelleher, Coronial Brief.
[15] Statement of Jillian Crompton, Coronial Brief.
[16] Created by a chemical reaction following smoke inhalation. Carboxyhaemoglobin is a complex molecule formed of carbon monoxide (product of incomplete combustion of hydrocarbons) and blood haemoglobin.

smoke first reached her. Sertraline[17] was detected at a therapeutic level and was not contributory to death.

24. The autopsy revealed no additional significant head, neck or torso trauma which may have caused or contributed to death, nor any other significant natural disease.

25. Dr Duffy provided an opinion that the medical cause of death was 1 (a) effects of fire, and I accept his opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Judith Ann Johns, born 15 June 1961;

    b) the death occurred on 03 July 2023 at 63 Upper Skene Street, Newtown, Victoria, 3220, 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 Judith's death was the consequence of the accidental ignition of this fire while Judith was cooking.

COMMENTS

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

28. The personal bravery of the neighbours and the courageous professionalism of the first responders is worthy of recognition and the gratitude of the broader Victorian community.

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

[17] An anti-depressant medication.

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:

Henry Johns, Senior Next of Kin

Leading Senior Constable Paul Stokes, Coroner's Investigator

Signature:

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Coroner Simon McGregor

Date : 23 October 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.