



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 6105

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Findings of:	Simon McGregor, Coroner
Deceased:	Mark Richard Mennie
Date of birth:	12 April 1963
Date of death:	2 December 2015
Cause of death:	Effects of fire
Place of death:	4 Harrison Street, Ringwood, Victoria 3134

HIS HONOUR:

INTRODUCTION

1. Mark Mennie was a 52-year-old man who lived in a boarding house at 4 Harrison Street Ringwood at the time of his death. Mr Mennie was unemployed and received government benefits.
2. On 2 December 2015, the Metropolitan Fire Brigade was called to a house fire at the Harrison Street property. At the time of the fire, Mr Mennie was asleep and alone inside the house. On their arrival, firefighters were alerted to the possibility that a person was trapped inside the burning house, and, upon extinguishing the fire, Mr Mennie was discovered deceased inside his bedroom.
3. The Victoria Police Arson and Explosives Squad and the Homicide Squad investigated the cause of the fire and Mr Mennie's death, as they believed the fire to be suspicious. Their investigations however, have not led to any person or persons being arrested or charged with indictable offences related to the fire to date.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mr Mennie's death was reported to the Coroner as it appeared unexpected and unnatural, and so fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) ('Act').
5. 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.
6. 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.
7. The Coroner's Investigator, Sergeant Brooke Manley, prepared a coronial brief in this matter. The brief includes statements from witnesses such as family, the forensic pathologist who examined Mr Mennie, investigating officers and medical records from treating clinicians.

8. In conducting this investigation, I have made a thorough forensic examination of the evidence, including reading and considering the witness statements and other documents 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.
9. In the coronial jurisdiction facts must be established on the balance of probabilities. This is subject to the principles enunciated in *Briginshaw v Briginshaw*.¹ 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.
10. In considering the issues associated with this finding, I have been mindful of Mr Mennie's basic 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.

BACKGROUND

11. Mr Mennie was the eldest of three children, born to Richard Mennie and Lorraine Stroud in Doncaster, Victoria.² Mr Mennie's parents separated when he was 12 or 13 years old, and he lived with his father until age 15 when he went to live with his mother.³
12. Mr Mennie initially attended East Doncaster High School, but left school at approximately age 15.⁴ After leaving school, he worked for a short time before he began receiving unemployment benefits.⁵ Mr Mennie left Victoria in his late teens and travelled around the country, living in Darwin, Queensland, Western Australia and Adelaide.⁶ During this period, he was known to use illicit substances regularly.⁷
13. In his twenties, Mr Mennie resided in Western Australia where he married his wife, "Cass".⁸ The relationship ended when Cass moved to Queensland with a new partner.⁹ While living in Queensland, Cass suffered a drug overdose requiring hospitalisation and life support.¹⁰

¹ (1938) 60 CLR 336.

² Statement of Richard Mennie dated 7 May 2018.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

As Mr Mennie and Cass remained married, Mr Mennie was forced to decide to withdraw her life support.¹¹

14. Following the death of his wife, Mr Mennie moved to South Australia. Mr Mennie's father said he worked as a stand over man and debt collector, and used drugs heavily during this time.¹²
15. Mr Mennie's father reported his son returned to Melbourne approximately ten years prior to his death.¹³ Mr Mennie moved in with his father and attempted to stop using drugs, however, was ultimately unsuccessful.¹⁴ According to Richard Mennie, his son struggled with substance abuse issues for most of his life.¹⁵

4 Harrison Street Ringwood

16. Approximately seven years before his death, Mr Mennie moved into 4 Harrison Street, Ringwood.¹⁶ The property was a privately-owned boarding house and Mr Mennie lived with a variety of people over the years. Mr Mennie and his sister, Dyane Mennie, were close and she lived in the house for four to five months towards the end of the tenancy. Ms Mennie moved out of the house approximately two weeks prior to the fire.¹⁷
17. It was not uncommon for Mr Mennie to have friends stay with him at Harrison Street and he regularly received visitors.¹⁸ Neighbours reported often hearing music and party noises coming from the house.¹⁹
18. In 2013, Mr Mennie commenced a relationship with Ms Jessie Johnston.²⁰ Ms Johnston also resided at the Harrison Street house for approximately six months.²¹ The couple separated for around two years, however, recommenced their relationship for a short period in late 2015, and Ms Johnston moved back into the Harrison Street residence.²² Ms Johnston

¹¹ Ibid.

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Statement of Dyane Mennie dated 3 December 2015.

¹⁷ Ibid.

¹⁸ Statement of Mark Reardon dated 13 July 2016.

¹⁹ Statement of Anne Sheath dated 23 August 2016.

²⁰ Statement of Jessie Johnston dated 2 August 2016.

²¹ Ibid.

²² Ibid.

reported Mr Mennie regularly used drugs including “ice” or methamphetamine during the periods she lived with him.²³

19. On 7 July 2015, the Harrison Street tenants were notified that the house was to be demolished, and they were required to vacate the property within 120 days. At the time, Mr Mennie, Dyane Mennie and another male, Sergio Alonso, resided at the property. The initial vacation date was set for 4 November 2015, however, Mr Mennie struggled to find alternative accommodation and was permitted to remain at the property until December.²⁴ According to his case manager, Mr Mark Reardon, the Notice to Vacate created anxiety for Mr Mennie. Mr Mennie became increasingly agitated, and his substance abuse increased during this period.²⁵
20. On 10 November 2015, Mr Mennie and Ms Johnston were involved in a domestic dispute and police attended the Harrison Street residence.²⁶ Following the dispute, Ms Johnston left the house and said she did not see or speak to Mr Mennie again.²⁷
21. Shortly prior to his death, Mr Mennie told his case worker, Mr Reardon, that he was “genuinely scared” of some of Ms Johnston’s friends. He told Mr Reardon he had at least one confrontation with Ms Johnston’s friends a few weeks prior to the fire, however, he did not provide specific details.²⁸

Medical history

22. Medical records obtained by my Investigator show Mr Mennie attended the Wantirna Road Medical Centre in Ringwood regularly. Mr Mennie’s medical history showed he suffered from a variety of medical conditions including hepatitis C, anxiety and depression, insomnia, asthma and benzodiazepine dependence. Attempts were previously made to reduce Mr Mennie’s benzodiazepine reliance, however, he suffered adverse reactions, and his intake remained relatively consistent prior to his death.²⁹
23. Mr Mennie primarily consulted with Dr William Cowell or Dr John Tescher. He was regularly prescribed baclofen, oxazepam, a salbutamol inhaler, tiotropium and diazepam.³⁰

²³ Ibid.

²⁴ Statement of Timothy Chapman dated 3 December 2015.

²⁵ Statement of Mark Reardon dated 13 July 2016.

²⁶ Statement of Jessie Johnston dated 2 August 2016.

²⁷ Ibid.

²⁸ Statement of Mark Reardon dated 13 July 2016.

²⁹ Wantirna Road Medical Centre medical records.

³⁰ Ibid.

Mr Mennie's records show he attended the clinic approximately fortnightly for fresh scripts of oxazepam and diazepam. However, the frequency of these attendances increased in the month prior to his death, perhaps as a result of the anxiety he felt having to move out, as was suggested by his case worker. The day before the house fire, on Tuesday 1 December 2015, Mr Mennie attended Dr Cowell in relation to his anxiety and depression. He was prescribed oxazepam (30 mg) and diazepam (5 mg).

24. Mr Mennie previously underwent treatment for his chronic hepatitis C, however, the treatment was unsuccessful, and he was awaiting further treatment at the time of his death. In the days leading up to the fire, it was noted Mr Mennie had not been feeling well, potentially as a result of his liver condition.³¹

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

Events preceding the fire

25. On 1 December 2015, Dyane Mennie visited her brother at 4 Harrison Street Ringwood and stayed the night at the house which she had recently vacated. Mr Mennie's friend, David Simons, was also at the house as he had been staying there for approximately two weeks.³² They watched movies and cleaned up around the house in preparation for the move.³³
26. On 2 December 2015, Mr Simons woke up at approximately 11:00am and had a cigarette with Mr Mennie. Mr Simons made Mr Mennie a cup of tea and noted that he was not feeling well that morning.³⁴ Meanwhile, Ms Mennie packed up her remaining belongings and asked Mr Simons to drive her home.³⁵
27. At approximately midday, Mr Simons used Mr Mennie's car to drive Ms Mennie home. While he was out, Mr Simons picked up another friend, Damien Cahill, and dropped into a Coles supermarket to purchase food for lunch. Mr Cahill had only recently become acquainted with Mr Mennie and was returning to the Harrison Street house to pick up some belongings he was storing there.³⁶
28. Mr Simons and Mr Cahill returned to the Harrison Street property where Mr Mennie was home alone and asleep in his room. Mr Simons stated Mr Mennie was lethargic that day as

³¹ David Simons, transcript of interview, 3 December 2015.

³² Statement of Dyane Mennie dated 3 December 2015.

³³ Statement of Dyane Mennie dated 3 December 2015; David Simons, transcript of interview, 3 December 2015.

³⁴ David Simons, transcript of interview, 3 December 2015.

³⁵ Statement of Dyane Mennie dated 3 December 2015; David Simons, transcript of interview, 3 December 2015.

³⁶ Damien Cahill, transcript of interview, 3 December 2015.

he was still feeling unwell and spent most of the time sleeping. According to Mr Simons, over the course of the day, Mr Mennie would wake up every few hours and smoke some marijuana before falling back asleep.³⁷

29. Mr Simons prepared lunch and hung out around the house and backyard with Mr Cahill as Mr Mennie slept.³⁸ While Mr Simons and Mr Cahill were in the backyard, Mr Mennie got up and made himself a sandwich before returning to his room to sleep.³⁹
30. Later that afternoon, Mr Simons joined Mr Mennie in his room and fell asleep on the couch while he waited for his Centrelink payment to arrive in his bank account.⁴⁰ At approximately 8:50pm, Mr Simons woke and checked his account and saw he had been paid. At around the same time, Mr Mennie got up to go to the bathroom. On his way back to his bed, Mr Simons said Mr Mennie was unsteady on his feet and fell over.⁴¹ Mr Simons asked Mr Mennie if he was okay and then checked to confirm that he had not hit his head in the fall.⁴² Mr Simons helped Mr Mennie back to bed and told him that he and Mr Cahill were going out to buy cigarettes and alcohol. Mr Mennie acknowledged Mr Simons as he fell back asleep.⁴³
31. Mr Simons and Mr Cahill left the Harrison Street property shortly before 9:00pm in Mr Mennie's car. Closed circuit television (CCTV) footage captured Mr Simons and Mr Cahill at 9:03pm purchasing cigarettes at Coles Ringwood. At 9:14pm, the pair were captured on CCTV in Mr Mennie's vehicle purchasing alcohol at the Thirsty Camel on Mount Dandenong Road, Ringwood. Following this, Mr Cahill stated they stopped at a friend's house in Dorset Road Croydon as he needed to repay \$200 he owed.⁴⁴
32. Mr Simons and Mr Cahill returned to 4 Harrison Street, Ringwood at approximately 9:40pm and discovered the house was on fire.⁴⁵

The fire

33. Shortly after 9:00pm on 2 December 2015, Mr Mennie's neighbour, Christopher Lapham, was sitting in the living room of his Harrison Street unit with his family. Mr Lapham was

³⁷ David Simons, transcript of interview, 3 December 2015.

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Ibid.

⁴¹ Ibid.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ Damien Cahill, transcript of interview, 3 December 2015.

⁴⁵ Statement of Sergeant Matthew Rizun dated 27 March 2019.

speaking to his sister, Sally Brouwer, when she alerted her brother that a house in the street was on fire.⁴⁶ Mr Lapham looked through his living room window and saw that the right side of a house in the street was ablaze. He immediately telephoned emergency services.⁴⁷

34. Mr Lapham was the first to report the fire at 9:05pm, however, the location of the fire was initially recorded as 15 Harrison Street, Ringwood. Following Mr Lapham's call, multiple neighbours telephoned in the event and confirmed the address as 4 Harrison Street, Ringwood.⁴⁸
35. While Mr Lapham was on the phone to emergency services, Ms Brouwer approached the house to investigate. As she moved toward the house, she heard moaning sounds coming from one of the front rooms. This was Mr Mennie's bedroom.⁴⁹ Ms Brouwer tried to help the person inside by breaking the window with a piece of discarded weatherboard. A passer-by, Andrew Dennis, also rendered assistance, and he and Mr Lapham broke a second window in an attempt to gain access to the house and communicate with anyone inside. They yelled into the bedroom and told the person to come to the window, however, there was no response, only murmuring.⁵⁰ By this time, the fire had begun to consume the left side of the house and Mr Mennie's bedroom was filled with smoke.⁵¹
36. At approximately 9:10pm, the Metropolitan Fire Brigade arrived and assumed control of the scene.⁵² Mr Lapham notified firefighters that they believed a person was trapped inside the house.⁵³ Firefighters began working on the area indicated by Mr Lapham, at which time the area was "fully involved" and human noises could no longer be heard.⁵⁴ Firefighters ran hoses through the shattered windows while other crews aggressively approached from the right side and rear of the premises in an attempt to control the fire.
37. At 9:33pm, a male victim was located by firefighters at the front of the house.⁵⁵ The male, who would later be identified as Mr Mennie, was confirmed deceased at the scene. At 9:44pm, the fire was deemed to be under control.⁵⁶

⁴⁶ Statements of Christopher Lapham dated 3 December 2015 and 16 September 2019.

⁴⁷ ESTA 000 records.

⁴⁸ Ibid.

⁴⁹ Statement of Sally Brouwer dated 2 December 2015.

⁵⁰ Statement of Andrew Dennis dated 2 December 2015.

⁵¹ Statement of Christopher Lapham dated 16 September 2019.

⁵² Statement of Senior Station Officer Uwe Oeser, undated.

⁵³ Statement of Christopher Lapham dated 16 September 2019.

⁵⁴ Statement of Senior Station Officer Uwe Oeser, undated.

⁵⁵ Ibid.

⁵⁶ Ibid.

Victoria Police Investigation

38. The fire and Mr Mennie's death were investigated by the Victoria Police Arson and Explosives Squad and the Homicide Squad. Officers from each of those units, as well as the Serious Crime Response Team and the Ringwood Uniform, attended the scene.⁵⁷ Between 2 December and 3 December 2015, the scene was examined and evidence collected.
39. Victoria Police obtained statements from neighbours and other witnesses to the fire, Mr Mennie's friends and family members, first responders and experts. Neighbours stated it was not uncommon to hear noises or a commotion coming from 4 Harrison Street, however, they did not report hearing suspicious noises on the night of the fire.⁵⁸
40. Initial inquiries focussed on persons connected to Mr Mennie immediately prior to his death. Police officers formally interviewed Mr Simons and Mr Cahill at the Ringwood Police Station, took swabs of their hands, obtained DNA samples and seized their clothing.⁵⁹
41. Subsequent to the initial investigations, Victoria Police received four Information Reports of note relating to potential persons of interest. Those people included people known to Mr Mennie and his associates, and people connected to his ex-partner, Ms Johnston. Potential persons of interest were interviewed by Victoria Police. The complete detail of Victoria Police's inquiries in relation to the four information reports did not form part of the brief in this matter, however, the information provided by my Investigator indicated that those inquiries were not fruitful and did not allow the investigation to progress further. Consequently, no person or persons has been implicated and charged with indictable offences in connection with Mr Mennie's death to date.

Fire investigation

42. On 3 December 2015, Rachel Noble, Victoria Police Forensic Officer and arson expert attended the scene of the fire. The residence at 4 Harrison Street, Ringwood, was a double fronted weatherboard house with an undercover porch. The front door opened onto an L-shaped hallway leading through the centre of the house to five bedrooms, a kitchen, a bathroom, a laundry, a toilet and a sunroom.⁶⁰ There was a raised deck leading to a large back yard and a driveway with a garage along the north side of the property.

⁵⁷ Crime scene log.

⁵⁸ Statement of Matt Stone dated 11 October 2016; Statement of Anne Sheath dated 23 August 2016.

⁵⁹ Statement of Mark Reardon dated 13 July 2016.

⁶⁰ Statement of Timothy Chapman dated 3 December 2015.

43. Mr Mennie's bedroom was at the front of the house, on the south-eastern side of the property, adjacent to the front door and porch area. The façade of the house, including Mr Mennie's bedroom, was largely hidden from street view by heavy foliage.⁶¹
44. Ms Nobel stated there was no evidence of forced entry into the property, except that which was consistent with firefighters entering the house. She commented that the bedroom near the covered porch area (Mr Mennie's bedroom) sustained the most fire damage, and the heaviest charring occurred to the weatherboards near the front door.⁶² She noted that among the debris were the remains of a cigar or similar smoking related material.
45. The front door mat was collected and tested for flammable liquids. Methylated spirits was detected on the mat.⁶³ No container was located near the point of origin to account for the presence of the methylated spirits.⁶⁴
46. Following her examination of the scene, Ms Noble concluded that the pattern and extent of the fire damage were consistent with the fire starting on the front porch, near the front door, by the ignition of available materials. She noted that the methylated spirits detected on the front door mat may have assisted the initiation or spread of fire. She stated there was no evidence of electrical fault or an electrical event such as 'arching', and the pattern of fire damage was consistent with the fire spreading toward, not from, the electrical meter box.
47. Potential sources of ignition which could not be excluded were direct ignition using a match or cigarette lighter, or, a carelessly discarded cigar or cigarette. Mr Simons stated that Mr Mennie was known to occasionally fall asleep while smoking a cigarette, and this had occurred at least three or four times in the month prior to his death.⁶⁵

IDENTITY AND CAUSE OF DEATH

48. On 4 December 2015, using fingerprint identification, the identity of the deceased was confirmed as Mr Mark Richard Mennie, born 12 April 1963. Identity is not in dispute and requires no further investigation.
49. On 3 December 2015, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine (VIFM), attended the scene and observed Mr Mennie in situ before he was transported to VIFM later that day for a full examination.

⁶¹ Photobook 1, exhibit 16.

⁶² Statement of Rachel Noble dated 12 February 2016.

⁶³ Statement of Rachel Noble dated 12 February 2016.

⁶⁴ Statement of Sergeant Matthew Rizun dated 27 March 2019.

⁶⁵ David Simons, transcript of interview, 3 December 2015.

50. Dr Lynch conducted an autopsy upon Mr Mennie's body and reviewed a post mortem computed tomography (CT) scan and the Police Report of Death for the Coroner. Dr Lynch provided a written report, dated 2 March 2016, in which he formulated the cause of death as '*I(a) Effects of fire*'.
51. Toxicological analysis of post mortem samples taken from Mr Mennie identified the presence of carboxyhaemoglobin,⁶⁶ hydrogen cyanide,⁶⁷ methylamphetamine,⁶⁸ amphetamine,⁶⁹ buprenorphine,⁷⁰ norbuprenorphine,⁷¹ naloxone,⁷² baclofen,⁷³ diazepam,⁷⁴ nordiazepam,⁷⁵ oxazepam,⁷⁶ temazepam,⁷⁷ amitriptyline,⁷⁸ nortriptyline,⁷⁹ delta-9-tetrahydrocannabinol⁸⁰ and 11-nor-delta-9-carboxytetrahydrocannabinol.⁸¹
52. Dr Lynch commented that there was evidence of extensive thermal injury to the body and of smoke inhalation, with sooty materials noted within the nostrils, mouth, trachea and bronchi. A blunt force injury (laceration) was also noted on the upper lip in the midline. Dr Lynch suggested the injury may have occurred as a result of debris from the fire falling onto Mr Mennie, however, the possibility that this injury was sustained prior to death could not be excluded.
53. I accept Dr Lynch's opinion as to cause of death.

⁶⁶ Carbon monoxide and hydrogen cyanide are gases produced from the combustion of organic fuels and plastic products. Levels of carboxyhaemoglobin that exceed 30% saturation, alone, may be life threatening.

⁶⁷ Ibid. Persons who die in fires can asphyxiate as a result of carbon monoxide and hydrogen cyanide during the combustion process.

⁶⁸ Amphetamines is a collective word to describe central nervous system stimulants structurally related to dexamphetamine. Methamphetamine is a strong stimulant drug and often known as "speed" or "ice".

⁶⁹ Amphetamine is a metabolite of methamphetamine.

⁷⁰ Buprenorphine is used to treat opioid dependency. It is an opioid with partial agonist activity. This means it has morphine like effects although they tend to be self-limiting at higher concentrations due to its partial antagonist activities.

⁷¹ Norbuprenorphine is a metabolite of buprenorphine.

⁷² Naloxone is a synthetic opioid antagonist used for the treatment of opioid dependency by preventing or reversing the adverse effects including respiratory depression, sedation and hypotension.

⁷³ Baclofen is used clinically for the relaxation of voluntary muscle spasm in multiple sclerosis; spinal lesions of traumatic or infectious degeneration, neoplastic and other origin causing skeletal hypertonus, spastic and dyssynergic bladder dysfunction.

⁷⁴ Diazepam is a sedative/hypnotic drug of the benzodiazepines class.

⁷⁵ Nordiazepam is a metabolite of diazepam.

⁷⁶ Oxazepam is a sedative/hypnotic drug of the benzodiazepine class.

⁷⁷ Temazepam is a metabolite of oxazepam.

⁷⁸ Amitriptyline is used to treat depression.

⁷⁹ Nortriptyline is a metabolite of amitriptyline.

⁸⁰ Delta-9-tetrahydrocannabinol is the active form of cannabis (Marijuana).

⁸¹ 11-nor-delta-9-carboxytetrahydrocannabinol is a metabolite of delta-9-tetrahydrocannabinol.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

54. As this matter is a suspected homicide, the Act mandated that I conduct an inquest.⁸² In the Victorian Court of Appeal case of *Priest v West*,⁸³ the Court noted:

If, in the course of the investigation of a death it appears that a person may have caused the death, then the Coroner must undertake such investigations as may lead to the identification of that person. Otherwise, the required investigation into the cause of the death and the circumstances in which it occurred will be incomplete; and the obligation to find, if possible, that cause and those circumstances will not have been discharged.

55. Accordingly, one of the purposes of holding an inquest is to investigate any evidence that may lead to the identification of the person (or persons) who may have caused the death, bearing in mind that I am required to make findings of fact and not express any judgment or evaluation of the legal effect of those findings.⁸⁴ However, section 7 of the Act specifically states that a coroner should avoid unnecessary duplication of inquiries and investigations, by liaising with other investigative authorities, official bodies or statutory officers. This is to allow for consideration of public interest principles that weigh against the potential benefits of any further investigation, such as additional cost to the community. It also acknowledges that, although a number of authorities or organisations may have the mandate to investigate, some are more appropriately placed than others to do so in any given circumstance. In this case, I acknowledge that Victoria Police have conducted a thorough investigation in this matter, and I shall not duplicate nor expand upon it.
56. Unfortunately, I have been unable to identify any person or persons as being responsible for causing the fire and Mr Mennie's death.⁸⁵
57. Based on the material available to me during the summary inquest, including the inquest brief, and in particular, the report of Ms Noble, I am satisfied however, on the balance of probabilities, that the fire was deliberately lit. The presence of methylated spirits on the front door mat, and the area where the fire originated, suggest it was most likely lit on the front porch, using methylated spirits as an accelerant.

⁸² Section 52(2)(a), *Coroners Act 2008* (Vic); Coroners are also permitted to hold inquests into fires pursuant to section 53 of the Act.

⁸³ (2012) VSCA 327.

⁸⁴ *Perre v Chivell* (2000) 77 SASR 282

⁸⁵ To the *Briginshaw* standard of the balance of probabilities, per reference 1.

58. It appears Mr Mennie, who was alone inside the house asleep, and potentially suffering the effects of illicit substance use and/or illness, was unable to escape his bedroom which was adjacent to where the fire commenced. Further, the evidence provided by Dr Lynch in relation to the blunt force trauma injury to Mr Mennie's face, also means I cannot exclude the possibility that Mr Mennie was assaulted around the time the fire was lit and was unable to leave the house due to injury.
59. Whatever the cause the of Mr Mennie's inability to escape the fire, the deliberate lighting of the fire ultimately culminated in his death and resulted from the actions of a person or persons' who intended to cause damage and/or harm.
60. Having reviewed Victoria Police's investigation, I am satisfied that no further investigation which I am empowered to undertake, would likely result in the identification of the person or persons who caused the fire and Mr Mennie's death. Whilst any investigation can be subsequently reopened if new evidence materialises, this particular investigation will now be closed, as all known avenues have been explored.

FINDINGS AND CONCLUSION

61. I express my sincere condolences to Mr Mennie's family and friends for their loss.
62. Having investigated the death, and having held an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008* (Vic):
- (a) The identity of the deceased was Mr Mark Richard Mennie, born 12 April 1963;
 - (b) The death occurred on 2 December 2015 at 4 Harrison Street, Ringwood from the effects of fire; and
 - (c) The death occurred in the circumstances described above.
63. Pursuant to section 73(1) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

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

- (a) Ms Lorraine Stroud, senior next of kin; and
- (b) Sergeant Brooke Manley, Coroner's Investigator.

Signature:



SIMON MCGREGOR
CORONER

Date: 26 September 2019

