IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006433

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Mr ECB[1]
Date of birth:	[redacted] 1975
Date of death:	03 November 2024
Cause of death:	1a: Effects of fire 2: Hypertensive heart disease, coronary artery atherosclerosis
Place of death:	Frankston South Victoria 3199
Keywords:	Fire death; Fire Rescue Victoria; ignition source likely unattended cigarette; high fire load; incapacity leading to failure to self-extricate; hard-wired smoke detectors

[1] This finding has been de-identified for the purposes of publication by order of Coroner Ingrid Giles.

INTRODUCTION

1. On 3 November 2024, Mr ECB[2] was 49 years old when he died in a house fire at his home in Frankston South.

2. Mr ECB had been living alone at the property since 2020. It was a two storey four-bedroom brick and brick-veneer property. The house was owned by Mr ECB's family.

3. Mr ECB is survived by a son whom he doted on. While his son did not live with Mr ECB at the Frankston South home, Mr ECB had a room set up for him should he ever wish to stay.

4. Mr ECB was also supported by his close-knit family including his mother and a small circle of friends including Ms FVL, who had known the family since her and Mr ECB were young, and was considered a close family friend of Mr ECB's. Ms FVL recounted that she would see Mr ECB almost daily and took to assisting him with driving him to appointments and tasks at home.

THE CORONIAL INVESTIGATION

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

8. Victoria Police assigned an officer, Detective Sergeant David Burgoyne, to be the Coronial Investigator for the investigation of Mr ECB's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the

[2] Referred to as 'Mr ECB' throughout my findings unless more formality is required.

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 Mr ECB 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]

Background

10. Mr ECB's family ran a successful business running car dealerships along with owning property and hotels. Mr ECB had worked within the family business at times, including as a publican.

11. Mr ECB was close with his father. His father passed away in 2022 which had a great impact upon Mr ECB. Ms FVL recounts that Mr ECB "*didn't take it well"* and his mother noted that "*Mr ECB was never the same after this... it really affected him. They were very close".*

12. Mr ECB was guarded about disclosing his medical history to loved ones, however records indicate that he had diagnoses of hypertension, renal failure, epilepsy and cellulitis. Mr ECB was treated by a general practitioner (**GP**) who monitored his conditions and prescribed him with medications to assist. In the months before his death, Mr ECB reportedly had a stroke.

13. Mr ECB also had a complex history of recreational drug use. His mother recounts that from the age of 17, he commenced using cannabis which he maintained until his death. His mother also recounted that his recreational drug use became problematic from when he was aged in his 20s. Medical records note Mr ECB had a diagnosis of polysubstance use disorder and that Mr ECB was a regular user of cannabis, amphetamines, gamma hydroxybutyrate (**GHB**), and methylamphetamine. His mother noted that Mr ECB made several attempts at outpatient rehabilitation to manage his substance use, to varying success.

14. Mr ECB also had a known history of alcohol misuse with a diagnosis of alcohol use disorder. Medical records reflect that Mr ECB's alcohol use resulted in recurrent falls and seizures that also on occasion caused him injuries that required care from hospital or his GP. Mr ECB's

[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.

recreational drug and alcohol use was discussed with him regularly with his GP who made attempts to provide treatment options and referrals for AOD support, but he declined. Mr ECB's GP noted on several occasions that Mr ECB was at the '*pre-contemplative stage of change*'.

15. Mr ECB had limited recorded history of mental ill health. His GP offered Mr ECB a mental health care plan in order for him to see a psychologist in context of his recreational drug and alcohol use but he declined. Mr ECB was future focussed having made future plans to see friends and plans to spend time with his son.

16. Mr ECB had a history of smoking cigarettes. He was known to smoke JPS red branded cigarettes. His mother recounts that sometimes he would "*light one, put it on the edge of his ashtray and walk awa*y". She said that she warned him against doing it, but he would demonstrate that the cigarette had self-extinguished and continued to do it.

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

Circumstances in which the death occurred

17. On 2 November 2024, Mr ECB made plans with Ms FVL for her to attend at his home the following evening.

18. On 3 November 2024, at around 3.00pm Mr ECB sent Ms FVL a text message asking her what she was doing and she replied that she was about to go to a concert and that she would see him later.

19. At some time around 6.25pm, Andrew Molenaar (**Andrew**), who is a First Lieutenant and volunteer firefighter with the Country Fire Authority (**CFA**), was in the backyard of his house in Frankston South and observed a "*large plum[e] of dark brown and black smoke".* Andrew checked his phone to see if fire services had been called to the fire and noted that they had not. He got in his car and commenced driving to the location of the smoke in order to locate the fire and so that he could call emergency services if required.

20. Andrew drove toward the smoke and turned into the relevant street in Frankston South and observed that the property at number 7 was alight and that smoke was coming from the roof of the property. He parked his car and ran towards the door of the house. He yelled out to neighbours, who had commenced coming out of their homes, and asked them to call

emergency services. He asked if there was anybody inside, but the neighbours were unsure if Mr ECB was there.

21. At 6.33pm emergency services were called to the property.

22. In order to establish if anyone was inside, Andrew tried to first enter the house from the front door but he couldn't get it open as it was presumably locked. He noted that the door was emanating heat and he then returned to his car to put on firefighting gear which he kept in his car for when he was required to attend to emergencies.

23. Andrew then turned the gas and power mains off. He observed that there were now large flames coming from a room situated on the northern side of the house. In order to try gain access to the rear of Mr ECB's home he went to a neighbouring property on the southern side of the property, and with the assistance of neighbours climbed a side fence.

24. Once in the back yard Andrew was able to access a garage built to the side of Mr ECB's house and opened the roller door to assist with access once emergency services arrived.

25. Andrew then went to the rear of the property and tried to open the back door, but it too was locked. He went around the property trying to see if there was another way into the house but could not locate anywhere safe or accessible.

26. He then returned to the front of the property by which time the front porch was now engulfed in flames. He made attempts to use the garden hose to quell the fire and waited for emergency services to arrive.

27. At 6.42pm, Fire Rescue Victoria (**FRV**) and Victoria Police arrived at the scene. On arrival they described the house as "*fully involved, the roof had collapsed*". Victoria Police assisted by securing the area. They also commenced making enquiries regarding who resided at the property and to see if they could establish the whereabouts of the residents.

28. Fire-fighting efforts continued however due to the extent of the fire it took FRV some time before the blaze could be brought under control.

29. At 7.50pm Victoria Police spoke to his mother and established that Mr ECB was the sole occupant at the property and that he was currently unaccounted for.

30. At 8.20pm, once the fire was out and it was determined by firefighters that it was safe to do so, officers from FRV entered the property to search for Mr ECB. FRV Officers recount that

this was difficult as the house was severely damaged and there was a lot of debris including bricks, roofing and collapsed walls.

31. FRV methodically searched each room carefully moving debris to check for any sign of Mr ECB. They first searched the bedrooms before searching what they believed to be the loungeroom of the house. They moved some bricks that were on the floor from a wall that had collapsed due to fire damage. At 9.18pm, they located human remains believed to be Mr ECB.

32. Victoria Police commenced an investigation into the fire at the scene. Officers secured the property until specialist forensic officers from Victoria Police and FRV could attend. They also located CCTV footage from neighbouring properties to assist in their investigation. No suspicious circumstances in relation to the source of the fire were identified.

Identity of the deceased

33. On 7 November 2024, Mr ECB (whose actual identity is recorded on the Court file), born [redacted]1 1975, was identified by fingerprint identification comparison.

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

Medical cause of death

35. Forensic Pathologist Dr Chong Zhou (**Dr Zhou**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted a computed tomography (**CT**) scan and autopsy on Mr ECB's body on 7 November 2024. Dr Zhou provided a written report of her findings dated 30 January 2025.

36. The post-mortem examination revealed that the cause of death was due to the effects of fire, which includes any one or a combination of burn injuries, and inhalation of toxic smoke and hot gasses. Dr Zhou noted that a contributing factor to Mr ECB's death was hypertensive heart disease and coronary artery atherosclerosis.

37. Dr Zhou commented that there was evidence that Mr ECB was alive and breathing at the time of the fire with soot inhalation within the airways and a significantly elevated carboxyhaemoglobin saturation. Dr Zhou explained that carbon monoxide is a gas produced from the combustion of organic fuels and plastic products that combines with haemoglobin in red blood cells to form carboxyhaemoglobin which is unable to bind oxygen. Mr ECB's level of carboxyhaemoglobin of ~ 42% means that approximately 42% of red blood cells in the bloodstream had lost their oxygen carrying capacity.

38. Dr Zhou noted that hypertensive heart disease is caused by longstanding hypertension in which the left ventricle, the heart's main pumping chamber, must work harder to overcome the increased pressure within the arteries of the body which confer increased resistance to blood flow. Dr Zhou explained that this leads to left ventricular hypertrophy (increased size and thickness) and increased muscle mass of the heart.

39. Dr Zhou explained that coronary artery atherosclerosis refers to a build-up of cholesterol and other material within the arterial wall that leads to narrowing of the arterial lumen with subsequent reduced delivery of oxygen and nutrients to the heart muscle.

40. Dr Zhou commented that the combination of hypertensive heart disease and focal severe disease of one of the main coronary arteries can lower the threshold of smoke inhalation required to trigger a fatal cardiac arrhythmia (abnormal heart rhythm).

41. Dr Zhou noted that aside from the thermal injuries, the post-mortem examination did not demonstrate any evidence of other significant trauma which could have caused or contributed to the death.

42. Toxicological analysis of post-mortem samples identified the presence of:

    a) Carboxyhaemoglobin at ~ 42% saturation

    b) Gamma Hydroxybutyrate (GHB)[4] at ~ 69 mg/l in the post-mortem blood.

    c) Methylamphetamine[5] at ~1.7 mg/l and its metabolite amphetamine at 0.2 mg/l.

    d) Delta-9-terahydrocannibinol[6] at ~ 32 ng/mL along with its metabolites 11-OH-delta-9-tetrahydrocannabinol at ~ 4ng/mL and 11-nor-delta-9-carboxytetrahydrocannabinol (THC-COOH) at ~44 ng/mL.

43. A toxicologist commented that the level of carboxyhaemoglobin detected in the samples can be considered life threatening.

[4] Gamma-hydroxybutyrate (4-hydroxybutyrate, sodium oxybate, GHB) is a colourless, odourless and slightly salty tasting liquid freely soluble in water. It has no legitimate therapeutic use in Australia and is therefore sourced from unregulated drug markets.

[5] Methylamphetamine (desoxyephedrine, metamfetamine, methamphetamine, MA) is the N-methyl derivative of amphetamine and has no legitimate therapeutic use in Australia and sourced from unregulated trug markets.

[6] Delta-9-tetrahydrocannabinol (THC) is the active form of cannabis (marijuana).

44. Dr Zhou provided an opinion that the medical cause of death was 1(a): *Effects of fire* and 2 *Hypertensive heart disease, coronary artery atherosclerosis*.

45. I accept Dr Zhou's opinion.

FURTHER INVESTIGATIONS INTO THE FIRE

46. John Kelleher (**FO Kelleher**), a Forensic Officer of the Victoria Police Forensic Services Centre, attended the residence and conducted an investigation into the cause of the fire.

47. Acting Senior Station Officer, Rod van Hattum (**SSO van Hattum**) of the FRV State Fire Investigation Unit also prepared a Fatal Fire Investigation Report

Environmental Conditions

48. FO Kelleher observed that the property was a brick and brick veneer property that was situated at the western end of the relevant street. FO Kelleher described the house as having a front door that opened into a hallway which led through the house. The hallway was partially blocked at the front by several piles of magazines. On the northern side of the house there was a bedroom at the front of the house that was unfurnished. Further down the hallway was a second bedroom which featured a double bed, walk in robe and ensuite bathroom. The northern side of the house also featured a laundry, bathroom and a further small bedroom. The southern side of the house featured a lounge room, kitchen, family room and a further bedroom. SSO van Hattum noted that the house construction did not appear to be a factor that contributed to the fatal fire.

49. FO Kelleher commented that the house had been severely damaged by fire with most of the damage being to the front of the house extending rearward. FO Kelleher noted that the ceiling had collapsed and ceiling joists and rafters were burnt causing the tiled roof to fall. FO Kelleher observed that some of the wall plaster had collapsed exposing burnt wall frames, particularly to the northern side of the building.

50. Both reports noted that the house was in some disarray with a large number of magazines and videos located in the front bedroom and hallway of the property. It was noted that these items along with the furniture constituted a high fire load which likely assisted the spread and intensity of the fire.

51. The reports of FO Kelleher and SSO van Hattum identified that one smoke detector was located and burned on the floor in the hallway of the house. FO Kelleher suggested the detector

likely fell from the ceiling of the property as a result of the fire. A battery could not be located in the terminal but FO Kelleher noted that the terminals were clean indicating that the battery may have become detached when the detector fell. FO Kelleher opined that it was unlikely the alarm was mains-powered and considered that, given that neighbours did not report hearing a smoke alarm, it may indicate that the alarm was not functional at the time of the fire (although he could not say it with certainty).[7]

52. FO Kelleher opined that the severity of the damage to the property raised the possibility that the fire had been burning for some time prior to being reported to emergency services.

Source of the Fire

53. The pattern of damage to the property indicated that the fire commenced in the second front bedroom of the property and commenced on the bed that was in the room.

54. FO Kelleher noted that the fire appeared to then spread to adjoining rooms and across the hallway into the lounge room. It was observed that the damage was not indicative of a flammable liquid being present and there was no evidence to suggest there were multiple points of ignition.

55. FO Kelleher identified three potential ignition sources:

    a) An unattended smouldering cigarette – the evidence suggests that Mr ECB had been smoking in the bedroom. A metal ashtray was located in the southeastern side of the bed where the fire likely commenced. Investigators also located several cigarette lighters and a burnt cigarette packet in the bedroom. Investigators also located a burnt-out cigarette placed upon a workbench in the (undamaged) shed which they offered is an indicator that Mr ECB may have had a habit of leaving burning cigarettes unattended.

    b) Electrical fault – electrical appliances were present in the bedroom including a lamp, air conditioner, television, gaming consoles and a DVD player. There were also certain battery-operated devices that FO Kelleher considered could have been an ignition source.[8]

[7] Conversely, Ms FVL recalled that there were multiple smoke detectors in the house and that she had replaced the batteries in them in August 2024 and as far as she knew they were in good working order at the time of the fire.
[8] These included adult toys and two Nintendo Switch game consoles.

c) Direct ignition of flammable and combustible material - the presence of flammable material within the bedroom such as furniture and magazines indicates a possibility that the materials were directly lit on fire. FO Kelleher opined that this ignition source is unlikely owing to the known circumstances, but it remained a possibility. He explained that it was generally difficult to definitively exclude direct ignition as a source of fire. FO Kelleher noted that the evidence does not suggest direct ignition and pointed to the fact there was no flammable liquids identified and only one ignition point.

Behavioural considerations

56. FO Kelleher observed that the location of Mr ECB's body indicates that he was likely sitting on a chair in the corner of the loungeroom and on becoming aware of the fire was unable to move much (if at all) beyond the chair. FO Kelleher opined that Mr ECB's inability or failure to become aware of the fire in time to evacuate implies a degree of incapacity.

57. Both reports noted Mr ECB's known history of drug use and the presence of glass pipes and smoking implements within the property.

58. FO Kelleher was of the opinion that it was likely that Mr ECB was either in a "*very deep sleep*" or intoxicated by drugs or alcohol or suffering from an illness that may have prevented him from becoming aware and evacuating after the commencement of the fire.

Conclusion of Investigators

59. FO Kelleher was of the opinion that the cause of the fire was the ignition of combustible material such as magazines and furniture in the second bedroom. FO Kelleher suggested that the fire ignited likely on the lower half of the double bed that was situated in the room.

60. FO Kelleher could not definitively determine the source of ignition but opined that a carelessly discarded or improperly extinguished cigarette or electrical fault were most likely.

61. SSO Hattum was of the opinion that the fire was "*accidental in nature*" however noted that a combination of behavioural and environmental factors may have contributed to the intensity of the fire and the ultimate outcome for Mr ECB.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr ECB , born [redacted] 1975;

    b) the death occurred on 03 November 2024 at 7 Goldborough Court Frankston South Victoria 3199, from 1(a) *Effects of fire,* (2) *Hypertensive heart disease, coronary artery atherosclerosis*.

    c) the death occurred in the circumstances described above.

63. Having considered all of the circumstances, I find that Mr ECB died from the effects of a fire that commenced within the bedroom of his property, with his significant burden of natural disease also being a contributing factor to his death.

64. While I cannot definitively determine the source of the fire, I consider that the weight of the evidence supports that it was most likely caused by an unattended cigarette. However, per the report of Forensic Officer Kelleher, there also remains the possibility of an electrical fault, or a failure of a battery-operated device. I accept the view of investigators that the amount of furniture along with large quantities of magazines and videos increased the intensity and severity of the fire, contributing to the fire load and it spreading throughout the property.

65. I further accept the conclusion of investigators that while it is possible that the fire started via direct ignition, it is unlikely, as there was no evidence to support the fire occurred on that basis or that there were any suspicious circumstances connected with the fire. There is also no evidence to suggest that Mr ECB lit the fire with intention to end his own life.

66. The circumstances including Mr ECB's known history of recreational drug use, along with the post-mortem toxicological results, indicate that Mr ECB was likely intoxicated at the time of the fire which likely hindered his capacity to become aware of the fire and evacuate to safety. Further, Mr ECB's medical history of extensive hypertensive heart disease and the coronary artery atherosclerosis identified in autopsy may also have reduced his capacity to escape the fire.

67. On the evidence before me, I am unable to determine whether the smoke detectors within the property were functioning at the time of the fire, though consider that evidence supports that there were definitely no hardwired or 'mains-connected' smoke detectors. This gives rise to a pertinent comment to which I now turn.

COMMENTS

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

1. The Coroners Court investigates multiple house fire related deaths each year. Many of these involve smoke detectors and alarms that have been inadequately maintained or otherwise rendered nonfunctional. As her Honour Coroner Dimitra Dubrow noted in her findings earlier this year in relation to three fatal fires between 2022 and 2024, echoing the message of Fire Rescue Victoria and the Country Fire Authority, "*only working smoke alarms save lives*".[9]

2. In her findings, Coroner Dubrow recommended that the Minister for Housing and Building (**Minister**) consider and assess Fire Rescue Victoria's recommendation to strengthen smoke detector and alarm system requirements in Victoria along the lines of the reforms introduced in Queensland, including mandating that smoke alarms in all homes, regardless of when built, be either hardwired or powered by a non-removable 10-year battery, be interconnected and less than 10 years old. Her Honour recommended that the Minister consult with Fire Rescue Victoria, the Country Fire Authority, the Victorian Building Authority and the responsible Queensland Minister in relation to the implementation of the legislative changes in that state.[10]

3. I consider that the circumstances of Mr ECB's tragic death underscore the importance of the recent recommendation made by Coroner Dubrow. The evidence in this case suggests that Mr ECB was alive at the time the fire started. While he faced a degree of intoxication and ill health that likely led to difficulties self-extricating from the fire (and which sadly is not an uncommon feature of the fire-related deaths I have investigated), and while the evidence is unclear as to the number and working order of battery-operated smoke detectors in his property, I consider that a hardwired set of smoke detectors in his property would have maximised the chances of Mr ECB or others nearby being alerted at an earlier point that a fire had broken out, and would have optimised his chances of survival.

4. Given that the fire started in Mr ECB's bedroom, likely from a cigarette, Mr ECB's death also underscores the dangers that can attend upon smoking inside the house, particularly where

[9] Findings into the passings/deaths without inquest of UYB (here), NGN (here), RTD (here) and QRB (here), Coroner Dimitra Dubrow, 20 May 2026.

[10] Coroner Dubrow also cited two previous recommendations from Victorian Coroners for the inclusion of sprinkler systems in all new residential buildings, regardless of height, commenting "*the presence of a sprinkler system in conjunction with a working smoke alarm would afford occupants, including vulnerable members of our community, greater opportunity to escape and survive fires*" – see COR 2020 003017, COR 2022 006787 and COR 2022 006788.

cigarettes are left unattended, along with the heightened safety issues that attend upon retention or 'hoarding' large quantities of flammable items, such as magazines.

5. It also underscores the importance of Fire Rescue Victoria's recommendation that smoke detectors are installed in bedrooms.

6. To this end, I have elected to notify my finding to the Minister, along with Fire Rescue Victoria (**FRV**), the Country Fire Authority (**CFA**), and the Victorian Building Authority, to assist in informing the ongoing efforts to move towards the Queensland model in which all smoke alarms in all homes, regardless of when built, must either be hardwired or powered by a non-removable 10-year battery; located in each bedroom and hallway on every level of a dwelling; be interconnected; and be less than 10 years old.[11]

7. It is imperative that the relatively simple opportunities to improve the safety of Victorians in their homes that have been highlighted by FRV and the CFA, and recommended by Victorian coroners – including to avoid the catastrophic and at times fatal effects of housefires – are vigorously pursued.

8. It must also be emphasised that every fatal housefire gives rise to the turnout of a large number of first responders for whom attendance at a fatality can have enduring impacts. The safety and wellbeing of our firefighters, police members, investigators and other first responders are matters of paramount importance, and further buttress the need for improved efforts to address preventable fire-related fatalities.

ACKNOWLEDGEMENTS

I thank the Coronial Investigator for preparing a thorough and considered brief.

I convey my sincere condolences to Mr ECB's family and loved ones for their profound loss.

I recognise and acknowledge the valiant efforts of first responders to the scene, including the off-duty firefighter who responded to the blaze ahead of the arrival of their colleagues.

[11] I note in this regard that the response to certain of her Honour former Coroner Jamieson's recommendations was recently provided by the Office of the State Building Surveyor, indicating that relevant discussions are currently underway regarding '*potential enhancements to the smoke alarm requirements contained within the Victorian Building Regulations'*. The response was issued on 8 September 2026 and is available here.

ORDERS AND DIRECTIONS

I order that a copy of this finding be published on the Coroners Court website in accordance with the Rules.

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

Mr ECB's mother, Senior Next of Kin

Mr ECB's brother

William Roberts Lawyers

Minister for Housing and Building

Fire Rescue Victoria

Country Fire Authority

Victorian Building Authority

Detective Sergeant David Burgoyne, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date: 11 September 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.