IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 007465

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	AQ
Date of birth:	2005
Date of death:	25 December 2024
Cause of death:	1(a) Firework injuries to the chest
Place of death:	Corner of Cloverton Boulevard and Pittsburgh Road, Kalkallo, Victoria
Key words:	Fireworks, accidental injury

INTRODUCTION

1. On 25 December 2024, AQ was 19 years old when he died in an accident involving fireworks. At the time, AQ lived in Victoria with his parents, MQ and SQ.

2. AQ was the youngest son of SQ and MQ, and younger brother to OQ.

3. At 14 years of age, AQ began working at his local supermarket and became an active member of his community, building relationships with coworkers and regular customers. AQ also helped out with OQ's landscaping business.

4. AQ was active and had a passion for the outdoors. Outside of work, he loved camping, fishing, gold prospecting, and riding motorcycles.

THE CORONIAL INVESTIGATION

5. AQ'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. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of AQ'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 AQ's death, 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.[1]

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

Identity of the deceased

10. On 31 December 2024, Coroner David Ryan made a formal determination identifying the deceased as AQ, born 2005, based on expert evidence of DNA comparison analysis.

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

Medical cause of death

12. Forensic Pathologist, Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 27 December 2024 and provided a written report of her findings dated 3 January 2025.

13. The post-mortem examination and computed tomography (CT) scan were consistent with the reported circumstances.

14. Routine toxicological analysis of post-mortem samples detected codeine,[2] morphine,[3] benzoylecgonine,[4] ecgonine methyl ester,[5] delta-9-tetrahydrocannabinol,[6] 11-OH-delta-9-tetrahydrocannabinol[7] and 11-nor-delta-9-carboxy-tetrahydrocannabinol (THC-COOH).[8]

15. Dr Baber provided an opinion that the medical cause of death was *"1(a) Firework injuries to the chest"*.

16. I accept Dr Baber's opinion.

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[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.
[2] Codeine is an opioid analgesic.
[3] Morphine is a narcotic analgesic indicated for moderate to severe pain. It is also the primary constituent in crude opium and a metabolite of codeine, ethyl morphine, heroin and pholcodine.
[4] Benzoylecgonine is a major metabolite of cocaine.
[5] Ecgonine methyl ester is a metabolite of cocaine.
[6] Delta-9-tetrahydrocannabinol (THC) is the active form of cannabis.
[7] 11-OH-delta-9-tetrahydrocannabinol is a metabolite of THC.
[8] 11-Nor-delta-9-carboxy-tetrahydrocannabinol (THC-COOH) is a metabolite of THC.

Circumstances in which the death occurred

17. On 25 December 2024, AQ celebrated Christmas with family at his home. AQ left home in his Toyota Hilux (**the Toyota**) between 7.30pm and 7.45pm to visit his friend, LR.

18. LR was at home with his friend, HB. AQ arrived at LR's home at around 8.00pm. AQ, LR, and HB discussed their trip to South Australia and their planned departure the following day.

19. A short time later, AQ wanted to go for a drive, as he had recently purchased LED whip lights for the Toyota. They left LR's home with AQ driving, LR in the front passenger seat, and HB in the rear left seat.

20. Sometime later, HB asked AQ to pull over for a short break. When AQ parked the Toyota near the corner of Cloverton Boulevard and Pittsburgh Road, Kalkallo, he exited the Toyota and entered a nearby vacant block of land. LR did not think much of this at first and he and HB remained near the Toyota.

21. LR observed AQ bent down on the ground, with a tube placed on the ground in front of him. LR and HB saw a flickering light – like a lighter trying to start. They then heard a large 'bang' and saw a bright light where AQ was bent over. HB later told police he knew a firework had gone off, as there were red sparks and smoke.

22. When the light faded, LR noticed AQ on the ground and rushed to his aid. LR described AQ's chest as 'open'. HB arrived at AQ's location seconds later and observed a hole in his chest. LR called emergency services.

23. Victoria Police Officers, Ambulance Victoria Paramedics and Fire Rescue Victoria responded, arriving at the scene a short time later.

24. HB and LR told Police Officers that they were not aware AQ was in possession of fireworks until the explosion.

FURTHER INVESTIGATIONS

25. On 26 December 2024, at around 12.12am, the Bomb Response Unit (**BRU**) attached to Victoria Police, attended the scene. A member of the BRU (**BRU Operator 19**) searched the Toyota and located eight 'Jumbo' crackers in the rear pocket of the driver's seat, one aerial shell in the rear pocket of the driver's seat, and three to four 'Whistling Moon' crackers on the driver's seat.

26. BRU Operator 19 searched around AQ's body and located a box of sand and a length of cardboard tube. There was a piece of cardboard sticking out of the bucket of sand and burnt remnants in the bottom of the cardboard tube. A cigarette lighter was also located on the ground near AQ's body.

27. The BRU determined that the cardboard tube had been used as a mortar, the charge cap was placed at the bottom of the tube, and the tube was placed in the box containing sand. The charge cap was then lit and exploded while AQ was leaning over the mortar.

28. Forensic Officer John Kelleher (**Officer Kelleher**), with the Victoria Police Forensic Services Centre, also attended the scene. Officer Kelleher observed several fragments of an aerial shell on the ground to AQ's left. Officer Kelleher opined that so few remnants of the aerial shell, suggest that the explosion occurred inside AQ and that any unconsumed fragments were trapped within the body. Due to the nature of the impact, Officer Kelleher concluded that AQ must have been leaning over the mortar, and given the incident occurred in a poorly lit area at night, this may have been inadvertent on his part.

29. Officer Kelleher seized the pyrotechnics discovered by the BRU, as well as a mailing tube plug, a PVC pipe, the mailing tube, fragments of burnt shell casing and part of a lifting charge cap, the box containing sand and a lifting charge cap, a cigarette lighter, and various aerial shell fragments.

30. Fireworks seized from the scene were identified as consumer-type fireworks. Fireworks of this kind may only be stored or used by persons holding a licence to use fireworks as a pyrotechnician, or other appropriate licence issued by the Victorian WorkCover Authority.

31. On 10 January 2025, Detective Senior Constable Grace Fryer (**DSC Fryer**), Coroner's Investigator, spoke to MQ, who was adamant that AQ did not have the fireworks in his vehicle when he left the family home on 25 December 2024. MQ later received information from a friend of AQs, that the fireworks came from an unspecified location in Roxburgh Park. DSC Fryer was unable to substantiate this claim.

32. DSC Fryer also received information from the uncle of a friend of AQ's, that he had found fireworks belonging to his nephew, DF. DSC Fryer made numerous attempts to contact DF between 9 April 2025 and February 2026 but was unable to obtain a statement from him.

33. On 2 March 2026, DF responded to DSC Fryer's email. In his response, DF stated that AQ purchased the fireworks from an unknown tobacco store in Craigieburn. DF further explained that he and AQ had been lighting fireworks together in the days preceding his death.

34. Ultimately, DSC Fryer was unable to verify the precise location where AQ had purchased the fireworks.

FINDINGS AND CONCLUSION

35. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was AQ, born 2005;

    (b) the death occurred on 25 December 2024 at the Corner of Cloverton Boulevard and Pittsburgh Road, Kalkallo, Victoria;

    (c) the cause of AQ's death was firework injuries to the chest; and

    (d) the death occurred in the circumstances described above.

36. The available evidence supports a finding that AQ's death occurred in the circumstances of an unfortunate accident involving unlawfully sourced fireworks when he inadvertently leant into the path of the firework after lighting the fuse.

37. I convey my sincere condolences to AQ's family and friends for their loss.

COMMENTS

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

38. As part of my investigation, I requested the assistance of the Coroners Prevention Unit (**CPU**)[9] to investigate the occurrences of deaths or emergency department presentations, in similar circumstances to AQ.

[9] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

39. The CPU used the National Coronial Information System (**NCIS**)[10] identified nine deaths resulting from firework injuries nationally since 2000, excluding that of AQ. All the deceased were male and aged between 16 years and 58 years.

40. The CPU then contacted the Victorian Injury Surveillance Unit (**VISU**)[11] at Monash University to ascertain how many hospital emergency department presentations have occurred in Victoria for non-fatal injuries due to fireworks. The VISU searched the Victorian Emergency Minimum Dataset for the period July 2015 to June 2025 and identified 215 emergency department presentations for injuries relating to fireworks. The data showed that firework injuries have generally declined over time.

41. Although only licensed pyrotechnicians – or people under their direct supervision – can use fireworks, it is perhaps unsurprising that people who do not fit this criterion will access them from time to time. Whilst it remains unclear where AQ purchased the fireworks, this case highlights the inherent dangers of underqualified individuals accessing and using fireworks.

PUBLICATION

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

[10] The NCIS is an Internet-based data storage and retrieval system of all deaths reported to Coroners in Australia and New Zealand since 2000 and 2007, respectively. It comprises coded and free-text data and up to four full text documents generated for the coroners' investigation, namely the summary of text from the police report of death to the coroner, autopsy report, forensic toxicology report, and coroners' findings. A limitation with the NCIS data is that the CPU are only able to search interstate cases where the coroner has completed the investigation ('closed cases') and the data does not include Western Australian cases.

[11] VISU maintains the Victorian Emergency Minimum Dataset (VEMD), which covers ED admissions to all Victorian public hospitals where a 24-hour ED is situated.

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

MQ & SQ, senior next of kin

Detective Senior Constable Grace Fryer, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 29 May 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.