



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003629

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sara Dennis
Deceased:	Lynette Elizabeth Stephenson
Date of birth:	1 February 1946
Date of death:	27 June 2025
Cause of death:	1a: Complications of cutaneous and airway burns
Place of death:	The Alfred, 55 Commercial Road Melbourne Victoria 3004
Keywords:	Fire, smoke alarms, fire prevention measures, wheat bag

INTRODUCTION

1. On 27 June 2025, Lynette Elizabeth Stephenson OAM was 79 years old when she died in hospital of injuries sustained in a fire at her home. At the time of her death, Lynette lived alone in Pakenham.
2. Lynette is survived by her son, Michael, sisters Marcia and Deborah, and grandchildren and great grandchildren. Her husband, Keith, predeceased her.
3. Lynette had a long career as a nurse, primarily administering infant immunisations. She was a great nurse and loved her work. She was also extremely involved in her local community, playing in the Cardinia Civic Concert Band, volunteering for the Red Cross (including taking on the role of Chairman for various periods), volunteering for the Pakenham Scouts (including being the District Leader of Development for the Cardinia District for many years), participating in the Pakenham Probus Club (including as President for various periods) and was centrally involved in the Pakenham Uniting Church. She was awarded an Order of Australia Medal in 2021 in recognition of her community service.
4. According to Deborah, Lynette was accident and injury prone and had suffered from broken bones. She had previously had bilateral knee replacements and back and ankle surgery. She also suffered from arthritis and chronic pain. Her mobility was compromised and she was unable to move quickly.

THE CORONIAL INVESTIGATION

5. Lynette'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 Leading Senior Constable Rachel Wallace to be the Coronial Investigator for the investigation of Lynette's death. LSC Wallace 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. Coroner Audrey Jamieson (as her Honour then was) originally held carriage of this investigation prior to her retirement in April 2026. I assumed carriage of this investigation on 27 April 2026 for the purposes of finalising the investigation and making findings.
10. This finding draws on the totality of the coronial investigation into the death of Lynette Elizabeth Stephenson 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

Circumstances in which the death occurred

11. On the morning of 26 June 2025, Lynette heated a wheat bag in the microwave and placed it on her bed before having a shower.
12. At 8:27am, Lynette called Triple Zero reporting there was a fire at her home. She stated that she was getting out of the shower and was audibly panicked. A smoke alarm was heard in the background of the call. Lynette then disconnected the call, and the evidence suggests she then attempted to extinguish the fire.
13. Fire Rescue Victoria (**FRV**) and Country Fire Authority (**CFA**) crews began arriving at the scene from 8:33am. At 8:35am, Lynette was removed from the home by fire crews and immediately placed in the shower of a neighbour's home to cool her.

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.

14. Ambulance Victoria arrived at the scene and commenced caring for Lynette. She told paramedics she had been in the ensuite of the master bedroom at the time the fire started and had to pass through the fire to leave the bedroom.
15. Deborah arrived at the scene and spoke to Lynette, who told her *“Deb, I was just getting out of the shower and my bedroom was on fire.”* She then said something about a heat bag.
16. Lynette was intubated at the scene and conveyed by air ambulance to the Alfred, arriving at 10:29am.
17. Lynette was transferred from the Emergency Department to the Intensive Care Unit. She was found to have 34% total body surface area burns and Grade 2/3 airway burns. Her burns were dressed and she was kept intubated and deeply sedated.
18. A family meeting was held with the Burns and ICU teams. It was determined that active treatment would not be in alignment with Lynette’s values and, in the context of her pre-existing frailty and medical comorbidity, she would be unlikely to enjoy a similar quality of life if she were to survive.
19. Lynette was transitioned to end-of-life care on the evening of 27 June 2026 and died at 11:55pm.

Identity of the deceased

20. On 30 June 2025, Lynette Elizabeth Stephenson, born 1 February 1946, was identified by dental record comparison.
21. Identity is not in dispute and requires no further investigation.

Medical cause of death

22. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 30 June 2025 and provided a written report his findings dated 3 July 2025.
23. The external examination showed extensive burns, including full thickness burns to the left and right sides of the chest and to the abdomen and anterior thighs.

24. Toxicological analysis of ante-mortem blood samples identified the presence of carboxyhaemoglobin at ~ 10% saturation and cyanide at < 0.5 mg/kg.² Midazolam, dothiepin, ketamine and paracetamol were also detected.
25. Dr Burke provided an opinion that the medical cause of death was *1(a) Complications of cutaneous and airway burns*.
26. I accept Dr Burke's opinion as to the cause of death.

FURTHER INVESTIGATION

Victoria Police

27. Scientist John Kelleher of the Victoria Police Forensic Services Centre attended at Lynette's address on 26 June 2025 and commenced an investigation into the fire. He subsequently provided a statement detailing his findings.
28. Mr Kelleher noted that the house was a double-fronted brick veneer building. The interior was *"tidy but very cluttered, with the accumulation of boxes of personal papers and household items bordering on a hoarding situation."* There were two smoke detectors, at the front and rear of the house. The rear detector was still operating at the time of Mr Kelleher's examination.
29. Mr Kelleher observed that the fire had occurred in the master bedroom. The mattress, bed frame and western bedside table were destroyed, and the eastern bedside table was severely damaged. Along the western side of the room were stacked books, shoes and what Mr Kelleher tentatively identified as a wheat bag heat pack. There were no other sources of ignition identified in the bedroom, except for a lamp on each bedside table.
30. The master bedroom door had been open at the time of the fire and there was some limited fire spread into the entry hall and lounge room. Severe and extensive sooting was evident throughout the home, which Mr Kelleher said suggested that the fire may have been burning for some time. The damage was not indicative of multiple points of ignition or of flammable liquid spread throughout the house.
31. Mr Kelleher concluded that the cause of the fire was the ignition of the bedding and other combustible material on the western side of the double bed in the master bedroom. There were

² Carbon monoxide and hydrogen cyanide are gases produced from the combustion of organic fuels and plastic products

no appliances, ashtrays, cigarettes, lighters or other obvious sources of accidental ignition in the vicinity. There were the tentatively identified remains of a wheat bag heat pack in the middle of the damaged area.

32. Mr Kelleher commented that an aged, deteriorated or overheated wheat bag heat pack is a potential source of ignition and, in the absence of any other apparent source, was considered to be the probable cause of the fire.

Fire Rescue Victoria (FRV)

33. FRV also attended at the scene and compiled a *Fatal Fire Investigation Report*. Their investigation was intended to identify any built environment and human factor fire safety issues contributing to the fire and Lynette's death.
34. FRV identified several factors that could have contributed to the fatal fire, including:
 - a) Lynette's mobility issues may have caused a delayed or hindered response in her evacuation attempt.
 - b) Clutter/ hoarding throughout the home rated at level 3 on the FRV Clutter Image Rating Scale.³ Investigators noted that access/egress paths were reasonably clear of obstructions. Most of the clutter was on benchtops and not at floor level but, in a smoke-filled environment, investigators hypothesised that it may have delayed or impeded a safe evacuation.
 - c) Inoperative/ineffective smoke alarms installed – the two smoke alarms at the property were not interconnected, and the smoke alarm at the front of the home was not installed on the ceiling but was on a buffet in the lounge area. Investigators hypothesised that it would have been extremely difficult for Lynette to have been alerted to the early stages of fire whilst in the shower.
35. FRV classified Lynette's death as a preventable fatality.

³ See <https://www.frv.vic.gov.au/hoarding>

FINDINGS AND CONCLUSION

36. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Lynette Elizabeth Stephenson, born 1 February 1946;
 - b) the death occurred on 27 June 2025 at the Alfred, 55 Commercial Road, Melbourne, Victoria 3004;
 - c) the cause of Lynette's death was complications of cutaneous and airway burns; and
 - d) the death occurred in the circumstances described above.
37. I am satisfied that the fatal fire was caused by a wheat bag igniting the bedding in the master bedroom.
38. I note the smoke alarm closest to the master bedroom may have been inoperable at the time of the fire. Although the other (rear) smoke alarm was operational, the distance between that alarm and the ensuite bathroom may have caused a slight delay in alerting Lynette to the fire in her home.
39. The evidence available to me indicates that Lynette attempted to extinguish the fire herself. Given she was required to pass through the master bedroom to escape the home, she may have felt she had no choice but to do so.
40. Having considered all of the available evidence, I find that Lynette's death was preventable.

COMMENTS

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

Wheat bags

1. Fatal fires caused by the ignition of a wheat bag are fortunately uncommon. A search of the Court's surveillance database indicated that only one other death occurring in the same circumstances was reported to the Victorian coroner since 2000. However, it is unclear how many non-fatal fires occur due to wheat bags. These may result in serious injury.

2. The dangers of wheat bags are well known. In 2013, the Australian Competition and Consumer Commission (ACCC) released a Product Safety Alert for wheat bags. The alert identifies the risk of fire due to wheat bags, including where they are heated in the microwave for too long, or are placed under bedding.⁴
3. In 2016, following an inquest into the death of an elderly woman in NSW following a fire caused by a wheat bag, the Australian Standard AS/NZS 5116:2016 *Microwavable heat packs – Wheat and other organic filling materials* was developed. The Standard addresses the design, construction, performance and labelling of microwaveable heat packs.
4. The Standard provides that the bag's filling material should not exceed 70 degrees Celsius and the surfaces of the bag should not exceed 50 degrees Celsius when heated in accordance with the manufacturer's instructions. A warning label must be attached to the bag stating:
 - Warning – fire and burn hazard
 - Do not overheat – always follow heating instructions
 - Do not use under bedding – may catch fire.
5. I am satisfied that appropriate regulations are in place for the manufacture and sale of wheat bags, and that there is significant information available to the public about the risks associated with their use. However, given I am finalising my investigation shortly after the end of Victoria's winter months when the weather is still cool, I consider it timely to recommend that the ACCC issue an updated product safety warning.

Smoke alarms and fire sprinklers

6. Lynette's home had two smoke alarms, though they were not interconnected. It appears that one of those smoke alarms was inoperable at the time of the fire as the body of the alarm was located on a buffet in the living area.
7. In Victoria, homes constructed before 1 August 1997 must have a battery powered smoke alarm installed. Homes constructed, or largely renovated, after that date must have smoke alarms connected to mains power with a back-up battery. Homes constructed or largely

⁴ <https://www.productsafety.gov.au/about-us/product-safety-news/news/wheat-bag-fire-hazards>

renovated after 1 May 2024 must have smoke alarms that are interconnected, hard-wired and have a back-up battery.

8. By contrast, Queensland legislation mandates that, by 2027, all smoke alarms in all homes regardless of when built must be either hard-wired or powered by a non-removable 10-year battery, be located in each bedroom and hallway on every level of a dwelling, be interconnected, and be less than 10 years old.⁵
9. Fire Rescue Victoria promote the message “*only working smoke alarms save lives*” and have advocated for Victorian smoke alarm regulations to contain additional requirements as contained in Queensland’s legislation.
10. My colleague Coroner Dimitra Dubrow recently handed down her findings into the deaths of four people who died in three fatal fires between 2022 and 2024.⁶ In those findings she made the following recommendation:

That the Minister for Housing and Building 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 and to 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. It is acknowledged that any mandatory changes to smoke alarm requirements may cause financial and other hardship to Victorian homeowners such that it is recommended that the Minister consider an appropriate lead time and support by way of rebates or discounts akin to that provided as part of the Victorian Energy Upgrades.

11. I endorse Coroner Dubrow’s recommendation. Although I cannot be certain, it is possible that an operable smoke alarm in the master bedroom may have alerted Lynette to the fire at a time where she was still able to escape.
12. Coroner Dubrow’s findings also commented on the utility of home fire sprinklers, saying “*[t]he 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*

⁵ The Queensland Government strengthened its smoke alarm legislation following the Slacks Creek disaster in 2011, where eleven people were killed in a house fire.

⁶ Findings into the deaths without inquest of UYB (COR 2022 007232), NGN (COR 2022 007231), RTD (COR 2023 000345) and QRB (2024 001662), Coroner Dimitra Dubrow, 20 May 2026.

and survive fires”. This issue has also been canvassed by Coroner Ingrid Giles⁷, and relevant recommendations have been made by Coroner John Olle⁸ and Coroner Audrey Jamieson⁹.

13. I understand that FRV and the CFA are engaged in advocacy work in this space and have worked with the Home Fire Sprinkler Coalition Australia, the leading national resource for independent, non-commercial information about home fire sprinklers. I encourage this important advocacy work, and the Court will continue to monitor these cases with a view to making recommendations as appropriate in future matters.

RECOMMENDATIONS

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

- (i) In the interests of preventing like deaths and promoting public health and safety, I recommend that the Australian Competition and Consumer Commission publish an updated product safety warning or similarly alert the general public to the risks associated with wheat bags.

I convey my sincere condolences to Lynette’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:

Michael Stephenson, Senior Next of Kin

Australian Competition and Consumer Commission

Fire Rescue Victoria

Country Fire Authority

Department of Families, Fairness and Housing

Leading Senior Constable Rachel Wallace, Coronial Investigator

⁷ COR 2022 006787, COR 2022 006788.

⁸ COR 2020 003017.

⁹ COR 2019 005734, COR 2020 001821, COR 2020 003949, COR 2020 004397, COR 2020 004808, COR 2020 004839.

Signature:



Coroner Sara Dennis

Date: 01 October 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.
