IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004121

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Christopher John Shaw
Date of birth:	24 August 1947
Date of death:	17 July 2025
Cause of death:	1a : Effects of fire
Place of death:	26 Church Street Carisbrook Victoria 3464
Key words:	Fire, residential fire, house fire, electrical fault, appliances, power board, public safety

INTRODUCTION

1. On 17 July 2025, Christopher John Shaw was 77 years old when he died in a house fire. At the time, Christopher lived alone in Carisbrook.

2. Originally from Sheffield, England, Christopher immigrated to Australia in 1947. With his wife, Marlene Bricknell (**Marlene**), the couple welcomed five children whom they raised in Maldon.

3. In 1994, Christopher, Marlene and their youngest child, Thomas Shaw (**Thomas**) moved to Church Street in Carisbrook. As Marlene's health declined, Christopher stopped working to take care of her and *'everything around the house'*. Sadly, Marlene passed away in 2010 which devastated Christopher.

4. Christopher spent his time volunteering in Maryborough and was involved with the local radio station. According to Thomas, he loved amateur radio (also known as ham radio); Christopher installed aerials and satellite dishes to the Church Street property and had them connected to his computers in the sunroom. Evidence indicates that *'the computers were on all the time and were never turned off'*. There was a power board at Christopher's desk in the sunroom, which likely connected several of his devices.

5. Following Marlene's death, Christopher's health began to decline. In 2024, Christopher fell while intoxicated and broke his hip. He was transported to Maryborough Hospital but according to Thomas, he *'discharged himself from the Hospital because he was refusing to take medication due to his conspiracy theories'*. The same year, he experienced another fall with long lie.

6. Thomas described that Christopher's health declined *'dramatically'* following these events; he was not eating properly, had *'8-10'* alcoholic drinks daily and began forgetting things. The Church Street house was *'dirty and unkempt',* and Christopher slept in an armchair in the loungeroom. At the time of his death, Thomas had recently had a *'conversation with [Christopher] to talk about putting him in a home care facility'* to provide extra assistance with daily living tasks.

7. With regards to fire prevention in the Church Street house, Thomas said:

'Dad's house had only one smoke detector in the house and that was in the kitchen, I am unsure if the batteries were even working in it as well as I hadn't changed them and not sure if Dad was able to because of his health.'

THE CORONIAL INVESTIGATION

8. Christopher'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.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Christopher'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.

12. This finding draws on the totality of the coronial investigation into the death of Christopher John Shaw 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]

[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.

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

Circumstances in which the death occurred

13. On 17 July 2025, at approximately 1am, Christopher's neighbours noticed that his house was on fire and they contacted emergency services. They approached the house and tried to raise Christopher but did not receive a response. Due to the severity of the fire, it was unsafe for them to enter the structure.

14. Country Fire Authority (**CFA**) firefighters arrived at the scene and began extinguishing the fire. Victoria Police also attended. By the time the fire was put out, the house was *'completely ruined'*. Inside, Christopher was located, clearly deceased, in the rear sunroom by his computer desk.

Identity of the deceased

15. On 28 July 2025, Christopher John Shaw, born 24 August 1947, was identified through a positive DNA comparison against a sample provided by his son, Thomas Shaw.

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

Medical cause of death

17. Forensic Pathologist Dr Matthew Lynch of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 21 July 2025 and provided a written report of his findings dated 28 July 2025.

18. The post-mortem examination revealed extensive burn injuries. A post-mortem computed tomography (**CT**) scan also showed burns, coronary calcification and mitral valve annulus calcification. There were also head-associated fractures of the skull, ribs and bones of the left forearm.

19. Toxicological analysis of post-mortem samples detected carboxyhaemoglobin at 51% saturation. Carboxyhaemoglobin occurs when carbon monoxide is inhaled and binds to haemoglobin – a protein in red blood cells. Carbon monoxide is a colourless and odourless gas produced by the incomplete combustion of organic fuels. By way of example, cigarette smoke has 4% carbon monoxide saturation, and automobile exhaust contains 0.5-10%.

20. When inhaled, carbon monoxide binds to haemoglobin with an affinity approximately 220 times greater than oxygen. The main role of haemoglobin is to carry and deliver oxygen throughout the body. When carbon monoxide binds to haemoglobin, it displaces oxygen with a net effect of reduced oxygen carrying capacity of blood and the delivery of oxygen to vital tissues and organs is reduced. This leads to progressive asphyxia that results in cellular hypoxia in tissues such as the brain and heart.

21. Carboxyhaemoglobin concentrations above 50% are considered potentially fatal.

22. Dr Lynch provided an opinion that the medical cause of death was 1(a) *Effects of fire*.

23. I accept Dr Lynch's opinion.

FORENSIC EXAMINATION OF THE FIRE

24. On the day of the fire, Kristen Cameron (**Ms Cameron**), a Forensic Officer of the Victoria Police Forensic Services Centre,[2] attended and examined the Church Street property.

Observations of fire damage

25. Inside the property, Ms Cameron documented that the house was cluttered and made observations similar to Thomas' description that the house was *'unkempt'*. There were no obvious signs of vandalism to the property and nor was there anything missing.

26. The sunroom had a metal roof and concrete floor. There was also a washing machine and a desk, atop which were *'various electronic equipment and soldering tools'*. There was an electric oil heater under the desk and electronic components and wiring on the ground. The plastic components of the electronic equipment and soldering tools had melted.

27. Ms Cameron identified a melted power board on the floor towards the rear of the desk with power cables plugged into the outlets. An additional power board, under the desk, had been completely destroyed. The plastic components and wiring insulation had been consumed in the fire and the bussbars remaining were distorted by heat. The paint had burned away from the oil heater which was unplugged with the cord wrapped over the top.

[2] Ms Cameron is a member of the Australian and New Zealand Forensic Science Society, the International Association of Arson Investigators and the Victorian Association of Fire Investigators.

28. Fire damage continued into the adjoining living room where there was a recliner chair, an armchair, entertainment unit, television and gas heater. Ms Cameron also identified the distorted metal frame of a walker in front of the recliner chair.

29. The office and kitchen also sustained heavy fire damage. The bedrooms had upper-level heat damage with the light fixtures having melted and heavy sooting on the walls, ceilings and surfaces.

30. Ms Cameron stated with respect to the origin of the fire:

> *'The pattern of burning and fire damage indicated that the fire started around the desk in the sun room and spread to the other rooms of the house.'*

Conclusion

31. Ms Cameron considered the pattern of fire damage and provided her conclusion as follows:

> *'[…] the fire started near the desk on the eastern side of the sunroom, by the ignition of available materials. There was no evidence to suggest flammable liquid had been used to initiate and/or spread the fire, nor were there any other areas of fire origin observed.*
>
> *The source of ignition was not determined. There was a power board on the ground on the northern side of the desk, which had sustained heavy fire damage. Due to damage, it was not possible to determine what had been plugged into the power board at the time of the fire. There were several electronic components and electric tools in the vicinity. The pattern of damage indicated that the fire had originated from an electrical fault related to the power board.*
>
> *Direct ignition using a match or cigarette lighter could not be excluded, however there was no evidence to support this type of ignition.'*

THE FREQUENCY OF POWER BOARD-ASSOCIATED FIRES

32. Christopher's death is one of many which have occurred in a house fire due to (or suspected to be due to) an electrical fault affecting a power board. At my request, the Coroners Prevention Unit[3] compiled data collected by the Court on similar deaths with a view to identifying trends and prevention opportunities.

33. The CPU identified 26 deaths since 1 January 2015 where an electrical fault was the confirmed ignition source. In five of these deaths (including Christopher), a power board was the suspected or confirmed locus of the electrical fault.

34. Data provided by Fire Rescue Victoria captured the incidence of fires ignited by power boards between June 2024 and January 2026 as 3.6 fires per month.[4]

35. Fires due to power boards occur indiscriminately and can have catastrophic consequences. They are, however, easily preventable. Evidence shows that the fire-risk of power boards increases when they are (i) faulty, or (ii) used improperly. Unfortunately, it is not uncommon for power boards to be used in a way that increases the likelihood of fire, such as:

    a) Overloading power boards, particularly with high-draw appliances,

    b) Untidy or tangled cords and wires,

    c) Connecting multiple extension cords or power boards, known as *'piggybacking'*; and,

    d) Using old or damaged power boards.[5]

36. I also note that the risk of power-board associated fires, and electrical fires more generally, increases in the winter. As the weather cools, Victorians will spend more time indoors and many will use additional appliances such as plug-in heaters and electric blankets.

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[3] 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.

[4] This includes fires irrespective of whether it caused injuries and/or death. The data provided by the FRV includes only fires where FRV was the primary incident controller and does not include data from other agencies such as the CFA.

[5] For additional information on the safe use of electrical products, see the Country Fire Authority's website at: https://www.cfa.vic.gov.au/plan-prepare/fires-in-the-home/home-fire-safety-communications-kit/electrical-safety.

37. Data provided by Fire Rescue Victoria demonstrated the general increase in power board-associated fires during winter months, with 14 reported fires having occurred in the winter of 2024, followed by only six fires in the summer of 2024-2025.

38. Indeed, Christopher's death occurred in the middle of winter. While the oil heater in Christopher's sunroom was not plugged in, according to Ms Cameron, I consider that its presence speaks to the behavioural patterns of Victorians in cooler months to rely on additional electric appliances for comfort. It is vital that these appliances are used cautiously and safely, particularly so when they are used in bedrooms and living rooms which likely include highly flammable soft goods, and near infants and children who are not alert to the appliances' fire risk.

CURRENT INITIATIVES REGARDING POWER BOARD-ASSOCIATED FIRES

39. The promotion of public health and safety is a core tenet of the coronial jurisdiction, and in so furthering that objective, I sought input from representatives of Energy Safe Victoria, Fire Rescue Victoria and the Australian Competition and Consumer Commission regarding fires associated with power-boards from their respective perspectives.

Energy Safe Victoria

40. Energy Safe Victoria (**ESV**) regulates electrical product safety under the *Electricity Safety Act 1998* (Vic), and its functions include to determine minimum safety standards for electrical equipment, investigating incidents which have implications for electrical safety and advise the community regarding electrical safety. The General Counsel and General Manager of ESV's Legal Governance and Regulatory Policy, Michelle McCorkell (**Ms McCorkell**) provided the Court with a statement dated 21 May 2026 regarding the organisation's regulation of and engagement with power board-related issues.

41. Power boards sold in Australia must comply with the standard AS/NZS 3105, developed by Standards Australia, and which covers matters including its protection against electric shock, overheating and fire, and marking and warning labels. The AS/NZS 3105 has evolved over time. A forthcoming change to the standard in 2026 will require additional protection to the socket outlets with a cover or shutter that will stop small metal parts from entering the aperture of the socket. Compliance with AS/NZS 3105 is enforced by ESV.

42. ESV does not maintain specific data on the compliance rate for power boards sold in Australia, Ms McCorkell told the Court. It does however undertake check testing and audits aimed at

monitoring compliance. As part of its Electrical Equipment Safety Scheme (**EESS**), ESV purchases electrical items from retailers and engaged independent accredited test laboratories to test the equipment against the relevant standard. ESV also conducts a point-of-sale audit program where retailers are audited annually for their compliance with EESS requirements, Ms McCorkell stated that power boards are usually included in these audits.

43. When asked about the growing availability of power boards from overseas or online retailers, Ms McCorkell stated that ESV provides consumers with information and guidance about the safe purchase and use of electrical equipment. These are available through many channels including the ESV website[6] and social media platforms.

44. Ms McCorkell outlined key safety messages for consumers:

    a) Purchase reputable brands from reputable suppliers and avoid suspiciously cheap products or unknown online retailers,

    b) Check and replace damaged equipment,

    c) Consider replacing older electrical products.

    d) Maintain household fire safety measures; and,

    e) Report safety concerns to ESV.

45. Most important, in my view, is that consumers purchase electrical goods – not only power boards – that carry the Regulatory Compliance Mark (**RCM**) which ensures that the product complies with relevant safety standards and requirements:

[6] Energy Safe Victoria *Electrical Appliances* website accessible at: https://www.energysafe.vic.gov.au/community-safety/buying-safe-appliances/electrical-appliances.

46. With regards to the issue of product labelling and specifically fire warnings on electrical products, Ms McCorkell explained that ESV does not have powers under its legislation to require fire danger warnings on power board packaging or labelling. While the AS/NZS 3105 standard does require some directions as to use (such as that they are not intended for continuous use), there is no requirement, at the time of writing, that a fire danger warning be displayed on the packaging.

Fire Rescue Victoria

47. The Deputy Commissioner of Fire Rescue Victoria (**FRV**), Joshua Fisher (**D/Commissioner Fisher**), provided a statement to the Court and articulated that FRV's primary concern regarding the use of power boards in Victorian homes relate to *'the overloading of power boards, continued use of damaged power boards, use of power boards that do not have a cut-off switch and power boards which do not meet Australian Standards.'*

48. D/Commissioner Fisher emphasised that power boards are only one subset of electrical fires and that the organisation identifies various electrical items in the home as being fire risks.

49. Community engagement and education through various media channels are a key component of FRV's commitment to public education. Its Community Resilience team regularly attends and hosts interactive community events intended to provide information on fire safety topics and preparedness. These initiatives, both in-person and online, are informed by trends in fires and tailored to the time of year (such as in winter) and frequency of risk. FRV has scheduled community presentations on residential fire safety, focussing on electrical equipment, to be held in early 2026, with additional dates to be held throughout the year.

50. FRV provides additional community-based education programs targeted at specific demographics including students at English language schools and centres, primary school age children, young people who have engaged in fire risk behaviours, migrants and active seniors.[7]

51. The FRV emphasised that its direct involvement only occurs once a fire has happened and therefore it was not in a position to comment on the sale, marketing or labelling of power boards in Victoria. D/Commissioner deferred to Energy Safe Victoria regarding these matters and simultaneously emphasised common misuse of power boards which have been discussed above.

[7] For more information on community education programs offered by the FRV, visit their website at https://www.frv.vic.gov.au/frv-education-programs-v2 or https://www.frv.vic.gov.au/community.

Australian Competition and Consumer Commission

52. The Executive General Manager of the Consumer Product Safety Division, Madeline Richardson (**Ms Richardson**), provided a statement dated 26 March 2026. Ms Richardson outlined that the electrical safety of consumer products is primarily regulated under State and territory legislation and corresponding agencies (for example, ESV). The role of the Australian Competition and Consumer Commission (**ACCC**) is limited, in this regard, to oversight of the national consumer product safety recall system.

53. Ms Richardson stated that electrical regulators play a key role in identifying unsafe electrical equipment and working with suppliers to warn consumers of safety risks. Electrical safety regulators can collaborate with the ACCC to publish voluntary supplier recalls on the ACCC Product Safety website.

54. Between 2016 and 2026, the ACCC published 10 power board-related recalls, with the most recent in January 2025. Most of these power boards were recalled as they did not meet required electrical safety standards and/or had faulty or non-compliant internal wiring or components.

55. The ACCC also received 136 supplier reports and consumer complaints and enquiries regarding power boards during the same period of 2016-2026. These contacts mainly consisted of malfunctioning power boards or faulty electrical items connected to power boards, with most consumers raising concerns about the risk of electrical shock or fire.

56. It is important that Victorians pay close attention to information published by the ACCC with regard to the recall of electrical appliances. Ms Richardson recalled an example that in December 2024, 13 recalls were received by the ACCC and so the Commission published a media release urging consumers to inspect their power boards at home, to check if they were using recalled power boards, to stop using any identified power board immediately and take appropriate action (to return to retailers for a return/exchange).

57. When asked about the proliferation of online and overseas retailers of power boards that may not meet Australian standards, Ms Richardson stated that the ACCC has not provided specific advice to consumers but has published general consumer guidance for buying safe products

online[8] and second hand products online[9] which contains information about the risks of shopping online, consumer rights, and tips for safe online shopping.

THE VICTORIAN ENERGY SAFE ROADMAP

58. Ms McCorkell of ESV pointed to the Victorian Government's recent 'Energy Safe Roadmap' (**Roadmap**), released in December 2025.[10] Developed by the Department of Energy, Environment and Climate Action, Action 2 of the Roadmap, titled 'Improve product labelling and efficiency of urgent product and related materials recalls', stated that:

> *'There is a growing risk of unsafe or non-compliant electrical products entering the Victorian market due to inconsistent labelling, poor traceability and delayed recall processes. Current regulatory powers limit the ability of Energy Safe Victoria to oversee product labelling and enforce compliance with Australian standards the point of import or sale.'*[11]

59. The Roadmap identified that strengthening labelling oversight will help to identify unsafe products earlier. The Victorian Government *'will consider options to strengthen labelling of products in Victoria, potentially through additional powers for regulators like Energy Safe Victoria'*. The Roadmap identified that this could include powers requiring labelling of products in respect of their fire hazard and pointed specifically to lithium-ion batteries.[12]

60. I fully support Action 2 of the Roadmap and encourage the Victorian Government to broaden ESV's powers accordingly with the view that Victorians can be better informed regarding potential fire hazards affecting items of daily use. I will direct that this Finding be distributed to the relevant Department for their notice of this Court's endorsement.

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[8] ACCC *Buying Online* website accessible at: https://www.accc.gov.au/consumers/buying-products-and-services/buying-online.

[9] ACCC *Buy safe second-hand products online* website accessible at: https://www.productsafety.gov.au/consumers/know-your-product-safety-rights/buy-safe-second-hand-products-online.

[10] Victorian Government, Department of Energy, Environment and Climate Action *Energy Safety Roadmap* dated 16 December 2025 and accessible at: https://www.energy.vic.gov.au/about-energy/safety/energy-safety-roadmap.

[11] Roadmap, p 44.

[12] Ibid.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Christopher John Shaw, born 24 August 1947;

   b) the death occurred on 17 July 2025 at 26 Church Street Carisbrook Victoria 3464, from 1(a) *Effects of fire;* and

   c) the death occurred in the circumstances described above.

2. I have considered all of the evidence, and I accept and adopt the conclusion of Ms Cameron. I find that the fatal fire most likely started due to an electrical fault affecting a power board in the sunroom.

3. There is an insufficient cogency of evidence to support a definitive finding as to the precise time that the fire started nor regarding Chrstopher's precise actions at that time. I note that the evidence suggests that he was at or near his desk in the sunroom at the time the fire started.

4. It is apparent that Christopher's health had significantly declined in the years leading up to his death and it is likely that owing to his advanced age and frailty, he was physically unable to extricate himself from the house once the fire started nor able to alert neighbours or emergency services to the blaze.

COMMENTS

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

Fires associated with electrical faults in power boards

5. Coroners have long been concerned with fatal fires and have engaged in preventative initiatives aimed at its various origins. In the context of electrical faults affecting power boards, I note the work of Coroner Audrey Jamieson[13] who investigated the 2009 death of 12-year-old, Timothy De Voight.[14] Timothy died in a fire caused by a power board, or an appliance connected to a power board, in his bedroom.

[13] As she then was.
[14] Finding into Death With Inquest regarding Timothy Joseph De Voight (COR 2009 5966), Coroner Audey Jamieson dated 23 November 2015 and accessible at https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/timothyjosephdevoigt_596609.pdf.

6. In investigating Timothy's death, Coroner Jamieson also referenced the 2009 fire at popular restaurant, Il Gambero on Lygon Street in Carlton. She identified that between the Il Gambero fire and Timothy's death, common threads emerged: namely that (i) multi-outlet power boards were located at the origin of both fires, (ii) the cause of both fires was either a power board or an appliance connected to the power board; and (iii) the power boards were being inadvertently misused at the time of both fires. Tragically, Christopher's death is strikingly similar, some 14 years later.

7. Her Honour held a joint inquest into Timothy's death and the Il Gambero fire and heard evidence from independent experts who all *'agreed that power boards are most commonly misused due to the public not understanding, or being unaware, that they are misusing power boards'*. Evidence was also heard that the age of a power board is a factor which *'can and will increase the risk of fire'* due to fair wear and tear and the general public continuing to use a power board until it fails. Energy Safe Victoria told the Court of its previous education campaign advising Victorians to replace power boards if they are *'cracked, bent, busted, discoloured'* and emphasised the importance of encouraging users to look for signs of deterioration or damage to power boards including *'discolouration of the plastics…loose contacts, physical damage, frayed leads, cracked cases and any signs of heat damage or water ingress'*.

8. It has been over 10 years since Coroner Jamieson handed down her findings into the two fires. Sadly, the Court continues to investigate preventable deaths that occur due to fires caused by electrical faults in power boards.

9. Christopher's death is yet another tragic reminder of the dangers associated with electrical faults in power boards, particularly when overused or overloaded. While the extent of the fire damage was such that I am unable to discern how many and what kind of electric appliances were plugged into the power board(s) at the time, evidence indicates that there were several electric devices in the vicinity of the origin at the fire. I also note Thomas' evidence that his father's computers were turned on all the time.

10. It is important that all users of power boards (and electrical products generally) do so safely and check whether the device meets relevant Australian safety standards. I encourage all Victorians to consult information published by ESV and look for the RCA mark when buying new electrical products.[15]

11. Having canvassed the current public education and community engagement initiatives active across the State, and which are facilitated by various agencies, I am hopeful that a continued effort to inform Victorians on the dangers of electrical appliances and power boards in particular may lead to a reduction in tragic residential fires, injuries and/or deaths that occur as a result.

ORDERS AND DIRECTIONS

I extend my sincere condolences to Christopher'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:

Mr Thomas Shaw, Senior Next of Kin

Fire Rescue Victoria

Australian Competition and Consumer Commission

Energy Safe Victoria

Department of Energy, Environment and Climate Action

Senior Constable Isaac Brewster, Coronial Investigator

[15] Energy Safe Victoria *Electrical Appliances* website accessible at: https://www.energysafe.vic.gov.au/community-safety/buying-safe-appliances/electrical-appliances.

Signature:

Coroner Leveasque Peterson

Date: 24 June 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.