



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Andrew McKee, Coroner, having investigated the death of Shane Patrick Riley

Find, pursuant to section 28(1) of the Coroners Act 1995, that:

- a) The identity of the deceased is Shane Patrick Riley;
- b) Mr Riley died in a house fire at his unit situated at 3/153 Gilbert Street, Latrobe;
- c) The cause of Mr Riley's death was incineration; and
- d) Mr Riley died on 11 June 2019 at Latrobe, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into the death of Mr Riley. That evidence is comprised of the following:

- a) an opinion of the pathologist who conducted the autopsy;
- b) relevant police and witness affidavits;
- c) medical records and reports;
- d) Fire Investigation Report prepared by Fire Investigation Officer A Goss; and
- e) forensic evidence.

Shane Patrick Riley was born in Footscray, Victoria on 18 January 1966 to parents Wayne and Gail Riley. He was 53 years of age at the date of his death.

Mr Riley grew up in Footscray and became an apprentice carpenter upon leaving school at the end of grade 9. He completed his apprenticeship and worked for other employers as a carpenter for 11 years. He then commenced his own business. From 2004 onwards he built cabins for a local caravan park. He was forced to retire in 2008 due to illness.

In 1996 he married Lynne Nyblom; the marriage ended after a year. Mr Riley then commenced a relationship with Leanne Albani and they had two children together. The family moved to Tasmania in 2004. That relationship ended in 2005 and Ms Albani moved back to Victoria with the children. The relationship was marred by family violence.

In 2013 Mr Riley commenced a relationship with a person known as "Meg." That relationship ended prior to her death. In 2016, Mr Riley met and commenced a relationship with Karen Hankin. They separated in 2018. The relationship was dysfunctional and marred by allegations of family violence. Both Mr Riley and Ms Hankin had issues with alcohol.

Mr Riley smoked heavily all his life and had issues with alcohol starting in his mid-thirties. In 2004, he was diagnosed with anxiety and depression. In 2008 he was diagnosed with chronic obstructive pulmonary disease. This disease severely restricted his mobility.

In 2015 and 2016 Mr Riley underwent treatment at a rehabilitation facility to address his dependency to alcohol. Unfortunately the treatment was unsuccessful.

In March 2019 Mr Riley had a fall at home that resulted in a hospital admission. He was diagnosed with a subdural haematoma. After his discharge from hospital Mr Riley indicated to family that he was not coping at home and wished to move into a nursing home. In May 2019, he was re-admitted to the North West Regional Hospital for pancreatitis. Upon his discharge from hospital he significantly reduced his alcohol and cigarette consumption with the assistance of his sister, Bridget Riley.

His family members advised the Coroner's Office of several attempts by Mr Riley to self-harm from 2005 to 2013. In April 2019 he attended the Spencer Clinic, North West Regional Hospital, with suicidal ideation, however he had no plans to act on those thoughts. His family stated his health was more stable at the time of his death.

Prior to the fire that caused Mr Riley's death his unit had been the subject of two previous fires. In 2017, Mr Riley fell asleep with a cigarette in his hand, which ignited the carpet. He was pulled from the burning premises by a neighbour. On 4 June 2019, Mr Riley set fire to a suitcase containing clothing that had belonged to his ex-partner, in the rear car park of his unit. Tasmanian Fire Service attended on both occasions to extinguish the fires.

Circumstances Surrounding Death

On 7 June Mr Riley contacted Ms Riley and informed her his television was malfunctioning and that he would like to purchase a new one. It was agreed he would attend Harvey Norman on the following Monday to inspect televisions and that Ms Riley would then order him one online.

Mr Riley attempted to repair the television. His cleaner noticed the back of the television had been removed, exposing the circuit board.

On 11 June 2019 Mr Riley was inside his unit. He telephoned his sister at around 9.00pm and left a message that he was going to buy a television. Sometime after this call, a fire started in the kitchen area. Combustible material near his mobility scooter battery that was re-charging caught fire. Mr Riley became aware of the fire and moved towards an exit. He collapsed to the floor. Tasmania Fire Service attended and extinguished the blaze and Mr Riley was located deceased approximately 2 metres from the exit. His unit was extensively damaged by fire.

Fire Investigation Report

A thorough investigation of the fire was conducted by Fire Investigation Officer, Anthony Goss. Fire Investigator Goss completed a comprehensive report dated 9 July 2019. As to the cause of the fire, Fire Investigator Goss provided the following opinion:

"My conclusion is that the cause of this fire is most likely from ignition of combustible materials in or around the battery charger located on the kitchen bench top. I was not able to completely rule out the possibility of combustible materials being on or around the battery charger which may have ignited as a result of the charger not being able to cool. i.e. the combustible materials restricting natural airflow.

Evolution of fire has spread upward and outward from the area of the battery charger leaving a burn pattern on the benchtop laminate, consuming the timber lining and shelf above and progressing through the rest of the structure.

With these findings the cause of this fire is found to be accidental."

I accept the opinion of Fire Investigator Goss that the cause of the fire was accidental.

Post-Mortem Examination and Toxicology Report

A post-mortem examination was conducted by State Forensic Pathologist, Dr Donald Ritchey. Dr Ritchey opined that Mr Riley's cause of death was incineration. I accept Dr Ritchey's opinion.

Toxicology testing of samples obtained at autopsy revealed a number of prescription medications at therapeutic levels and a blood alcohol reading of 0.146 g/100mL.

I am satisfied that Mr Riley died in an accidental house fire. Based on the report of Fire Investigator Goss, I am satisfied that the cause of the fire was found to be accidental. I am satisfied that Mr Riley did not take any steps to bring about the end of his own life.

Findings, Comments and Recommendations

I am satisfied from the police investigation that there are no suspicious circumstances surrounding Mr Riley's death and that no other person was involved in his death.

I have decided not to hold a public inquest into this death because my investigation has been sufficient to disclose the identity of the deceased, the date, place, and cause of death, relevant circumstances concerning how his death occurred and the particulars needed to register his death under the *Births, Deaths and Marriages Registration Act 1999*. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigation conducted by me. The circumstances of the death do not require me to make any further comment or to make any recommendations.

I convey my sincere condolences to Mr Riley's family and loved ones.

Dated: 12 May 2020 at Hobart in the State of Tasmania.

**Andrew McKee
Coroner**