I, Olivia McTaggart, Coroner, having investigated the death of Murray Geoffrey Noble

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

(a) The identity of the deceased is Murray Geoffrey Noble;

(b) Mr Noble died in the circumstances set out further in this finding;

(c) Mr Noble died as a result of asphyxia due to inhalation of products of combustion from a house fire;

(d) Mr Noble died on 8 July 2015 at his home at 18 McKellar Street, South Hobart in Tasmania; and

(e) Mr Noble was born in Hobart, Tasmania on 30 July 1933 and was aged 81 years at the time of his death.

In making the above findings I have had regard to the evidence gained in the investigation into Mr Noble’s death. The evidence comprises the police report of death, a report from Tasmania Fire Service investigators, an opinion of the forensic pathologist who conducted the autopsy, relevant police and witness affidavits, and medical records.

I make the following further findings regarding the circumstances of Mr Noble’s death.

Mr Noble was 81 years of age. He was a widower and retired. He had three children and lived with his grandson, Daniel Brown (“Mr Brown”), at 18 McKellar Street, South Hobart.

Mr Noble’s physical health was generally good but in the years prior to his death his mental health began to decline. In 2014 he was diagnosed with vascular dementia. Despite this diagnosis, Mr Noble lived mostly independently and was given care by his children and grandson. His daughter, Susan Noble-Brown, would assist him with household duties and with managing his medical appointments and finances. In the six months prior to his death there was a further decline in his mental health and ability to independently care for himself. Nevertheless, Mr Noble was active, socially engaged, and well supported. Whilst he was prone to confusion, his family had not observed him undertaking actions that would put him at risk of harm.
On 7 July 2015 Mr Noble was at home with Mr Brown at 18 McKellar Street, South Hobart. At around 5.00pm Mr Noble lit a fire in the wood heater in his lounge room, as was his usual practice in the winter. Mr Brown left the premises at around 11.00pm, leaving Mr Noble alone in the home. Mr Noble was still awake at that time.

At 4.25am on 8 July 2015 Tasmania Fire Service was alerted to a fire at Mr Noble’s residence by his neighbour, Ms Tink Gee. Ms Gee was woken by the sounds of the fire, including the windows shattering, and noted that the house appeared to be fully engulfed in flames.

A crew of fire fighters attended the scene at around 4.30am. The fire was in an advanced stage. Once the fire was contained by fire fighters, they entered the residence through the front door. Mr Noble was located deceased on the kitchen floor towards the rear of the residence. Fire fighters forced entry through a locked door leading to the laundry and then outside.

Tasmania Fire Service investigators attended shortly after the fire was extinguished and conducted an investigation. They observed and documented the scene. The investigation revealed that the fire began in the lounge room of the residence, in an area next to the wood heater. They found no other source of the fire. The wood heater door was found to be closed and on the lowest setting, with the glass intact. No evidence was found to indicate that the heater was the cause of the fire. Investigators concluded that the source of the fire was most likely from a smouldering log that had been placed on the floor, remnants of which were still visible. Mr Brown stated that Mr Noble would often remove logs from the wood heater when it became too hot or appeared over stacked, although he would not usually place them in the wood box or on the floor next to the wood heater.

On the basis of the fire investigators’ conclusions, and all of the evidence, I find that Mr Noble tended to the wood heater whilst he was alone in the house before going to bed. He removed a log of wood from it and placed it on the floor or in the wood box beside the heater. He was either unaware that it was still smouldering or gave no thought to the fact. Whilst Mr Noble was in bed the log continued to slowly smoulder and eventually ignited the surrounding area, initially setting alight the carpet and floorboards.

The evidence indicates that Mr Noble awoke, either because of the fire alarms or noise from the fire, to discover the fire in an advanced stage. He then opened the door of another bedroom of the residence, most likely to look for his grandson. He then entered the kitchen where he was overcome by smoke and gases from the fire, causing his death. A saucepan of water was located near Mr Noble and the kitchen tap was turned on, indicating an attempt by him to extinguish the fire. The fire investigators were unable to determine whether Mr Noble had attempted to exit through the locked back door or was overcome prior to being able to reach the door. It was Mr Noble’s practice to lock the back door with a key and hang the key on a nail close to the door. The key to the locked back door was not found.

Mr Noble was in good spirits on the evening before his death, and I am satisfied that he had no intention to harm himself. I am also satisfied that he did not intend to start the fire or ignite
his residence. I am further satisfied that there were no suspicious circumstances surrounding the cause of the fire or Mr Noble’s death. It would appear that Mr Noble’s increasingly confused state of mind contributed to him placing the smouldering log on the floor, and contributed to an inability to remove himself from the house.

Mr Noble’s home was fitted with two smoke alarms. Evidence from Mr Noble’s family members was that the alarms had not been checked for some time, and one of the alarms had been beeping. I am not able to determine whether the alarms were operational at the time of the fire. The investigators did not locate their remains. It is possible that they did activate but that Mr Noble did not hear them. The evidence indicates that mental impairment and being alone in a house are factors that greatly reduce the likelihood of responding appropriately to an activating smoke alarm when asleep.

Dr Donald Ritchey, forensic pathologist, conducted an autopsy on Mr Noble. He found the cause of Mr Noble’s death was asphyxia due to inhalation of the products of combustion from the fire. Dr Ritchey also noted the presence of advanced atherosclerosis coronary vascular disease which contributed to death. I accept Dr Ritchey’s opinion as to cause of death.

Comments and Recommendations:

The circumstances of Mr Noble’s death are not such as to require me to make any comments or recommendations pursuant to section 28 of the Coroners Act 1995.

I acknowledge the efforts of the Tasmania Fire Service fire fighters who extinguished this significant fire and recovered Mr Noble from the residence.

I am also grateful for the work of Tasmania Fire Service investigators, Mr Barry Bones and Mr John Ling, which has greatly assisted me in the investigation.

I extend my appreciation to Constable Rosemary Cassidy for her investigation and report.

I convey my sincere condolences to the family and loved ones of Mr Noble.

Dated: 13 March 2017 at Hobart in the state of Tasmania.

Olivia McTaggart
Coroner