Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Andrew McKee, Coroner, having investigated the death of Phyllis Mabel Pears

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

a) The identity of the deceased is Phyllis Mabel Pears;
b) Mrs Pears died as a result of incineration in an accidental house fire;
c) Mrs Pears' cause of death was incineration; and
d) Mrs Pears died on 29 May 2019 at West Moonah, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mrs Pears' death. The evidence includes:

a) The Police Report of Death;
b) An opinion of the Forensic Pathologist who conducted the post-mortem examination;
c) Police, family and witness affidavits;
d) A fire investigation report;
e) Medical records and reports; and
f) Forensic evidence.

Mrs Pears was born in Queenstown, Tasmania on 4 January 1929 and was aged 90 at the date of her death. She was married to Mr Horace Pears. Their marriage produced two children.

Mrs Pears was a qualified primary school teacher. She returned to teaching after raising her family. She taught at Springfield Gardens, Bridgewater and St Therese's Primary Schools.

Mrs Pears lived independently at her home situated in West Moonah. She was assisted in her independent living by extended and home care provided by Glenview support. Mr Pears resided in a nursing home. Mrs Pears was visited by multiple family members most days.

Mrs Pears' medical history is fully outlined in her medical records and I am satisfied that her physical health in no way contributed to her death. I note that Ms Pears had limited mobility and I am satisfied her limited mobility was a factor in her death.
Circumstances Surrounding Mrs Pears’ Death

On the morning of 28 May 2019, Mrs Pears was at her home with her carer, Ms L Dodds. Mrs Pears informed Ms Dodds that she was not feeling well. Shortly after, she suffered a medical event and was transported to the Royal Hobart Hospital by ambulance.

On 29 May, Ms Dodds was requested by her employer to collect Mrs Pears from the hospital as she was being discharged and to transport her back to her home.

I requested Dr A Bell, an experienced medical practitioner attached to the Coroner’s Office, to review the decision to discharge Mrs Pears from hospital on 29 May 2019. Dr Bell provided a report to me wherein he indicated the decision to discharge Mrs Pears was appropriate.

Ms Dodds transported Mrs Pears to her home. Shortly after her arrival at home Mrs Pears was visited by her grand-daughter in law, Ms Lewis. Mrs Pears advised Ms Lewis she had a kidney infection. They then had a general discussion about family and other matters.

Ms Dodds was present during Ms Lewis’ visit, performing a variety of tasks throughout the house.

Ms Lewis offered to make Mrs Pears something to eat and offered to warm up a heat pack. Mrs Pears declined both offers. Ms Lewis left shortly after 1.45pm.

At approximately 2.20pm Mrs Pears’ neighbour, Mr Thapa, heard the sound of breaking glass. He went outside and saw that the kitchen window of Mrs Pears’ residence had shattered. He observed black smoke discharging from the broken window and flames in the kitchen. He immediately contacted 000.

Both police and firefighters attended. After the fire was extinguished, Mrs Pears was located inside the kitchen. She was deceased.

Officers of the criminal investigation branch attended the scene. I am satisfied as a result of the police investigation that there are no suspicious circumstances surrounding Mrs Pears’ death.
Fire Investigation Report

A fire investigation report was completed by Fire Investigation Officer, Mark McCarthy. It is clear from the report that Mrs Pears had been in the process of heating wheat packs when the fire started. I note the following from Officer McCarthy's report:

"Summary of investigation findings

The wheat bags have been heated in the microwave and placed in a pile on the chair against the roller door between the kitchen and dining room. Due to being piled, the wheat bag has been unable to give off heat and has self-heated to the point of igniting the combustible material bag and a small amount of wheat. This has caused a small isolated fire.

Probable chain of events

I believe [Mrs] Pears was heating wheat bags in the microwave and then placing them on the chair. During this process, a wheat bag has ignited and either [Mrs] Pears has attempted to extinguish or was leaning over the pile of wheat bags at ignition. The close proximity of [Mrs] Pears to the fire and her limited mobility has resulted in igniting [Mrs] Pears' clothing....

Conclusion

Considering the timeline of events preceding the fire, information obtained from persons at the incident scene, physical fire language indicators and observations, I have determined the point of origin was from a wheat bag sitting on the chair against the roller door between the kitchen and dining room.

The cause of the fire was a wheat bag that has been heated in the microwave and placed on the chair in a pile with other heated wheat bags. Due to being piled, the wheat bag was unable to go through its usual exothermic reaction (releasing heat). The inability of the wheat bag to release heat whilst piled with other wheat bags releasing heat has caused the wheat and material bag to spontaneously ignite.

At no time during the investigation was there any evidence found to suggest a natural electrical ignition source or any information or evidence to suggest that the cause of the fire was associated with a deliberate ignition source.

The cause of this fire is classified as Accidental."

I accept Officer McCarthy's opinion as to the cause of the fire.
Post-Mortem Examination

A post-mortem examination was conducted by Forensic Pathologist, Dr Donald Ritchey. Dr Ritchey opined that Mrs Pears' cause of death was incineration. I accept his opinion as to Mrs Pears' cause of death.

Wheat Packs

According to the Tasmania Fire Service website, wheat packs have been responsible for causing a number of house fires.

To address this issue the Tasmania Fire Service has produced a Fact Sheet dealing with the use of wheat packs. That Fact Sheet is available here.

Comments and Recommendations

I extend my appreciation to investigating officer, Constable Connor Young, for his investigation and report.

I make the following recommendations:

1) That individuals in possession of wheat packs without instructions as to their use immediately cease use of such wheat packs.

2) That members of the public familiarise themselves with the Fact Sheet prepared by Tasmania Fire Service prior to using wheat packs.

I convey my sincere condolences to the family and loved ones of Mrs Pears.

Dated: 11 September 2020 at Hobart Coroner's Court in the State of Tasmania.

[Signature]

Andrew McKee
Coroner