



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION



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## **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Simon Cooper, Coroner, having investigated the death of Douglas Ian Scott

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

- a) The identity of the deceased is Douglas Ian Scott;
- b) Mr Scott died in the circumstances set out below;
- c) The cause of Mr Scott's death was oxygen deprivation and carbon dioxide toxicity in a person with chronic respiratory insufficiency; and
- d) Mr Scott died on 3 October 2016 at 81 High Street, Mathinna, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Scott's death. The evidence comprises an opinion of the pathologist who conducted the autopsy; relevant police and witness affidavits; medical records and reports; and forensic and photographic evidence.

Mr Scott was married to Christine for 39 years. They lived at Mathinna for most of their married lives. Mr and Mrs Scott had 3 children, one of whom died in infancy.

Reportedly a heavy smoker and a plumber who was exposed to asbestos during his working life, Mr Scott was diagnosed with emphysema around 4 years before his death. His condition gradually deteriorated such that he required hospitalisation in early September 2016. Mr Scott was discharged home with an oxygen concentrator to help him breathe. The concentrator delivered pure oxygen via two (2) rubber tubes directly to his nose.

Whilst at hospital in St Mary's Mr Scott was shown how to use the oxygen concentrator. Part of that education session involved a clear and unequivocal warning to not use the device whilst smoking or near an open flame. Mr Scott signed an acknowledgment that he was aware of the conditions for safe use of the concentrator. Mrs Scott confirmed to police investigating her husband's death that he was aware it was dangerous to use the device near an open flame or whilst smoking.

The device itself has a large label warning against use whilst smoking or near an open flame.

Mr Scott was advised by his doctor to cease smoking altogether.

However, Mr Scott continued to smoke and appears to have quickly ignored or forgotten the advice to not use the concentrator whilst smoking or near an open flame. His wife cautioned him against using the device whilst smoking but he dismissed her advice.

On Monday 3 October 2016 at about 12.50pm, Mr Scott was sitting in a chair in the lounge room of the family home. Mrs Scott was nearby, in the bathroom. She heard him call out. She rushed to the lounge room and saw Mr Scott crouched over a chair, trying to find the oxygen tubes, which were on the floor, burnt. She saw a lit cigarette on the floor which her husband had been smoking.

Mrs Scott obtained a spare set of tubes and tried to set those up for her husband. He was struggling to breathe. She sought help from a neighbour. Together they placed Mr Scott on the floor where he died. Ambulance personnel attended but were unable to revive Mr Scott.

Police attended and conducted investigations at the scene. Mr Scott's beard, lips and nose were noted to be burnt. No signs suggesting suspicious circumstances were identified at the scene. After formal identification, Mr Scott's body was transported by mortuary ambulance to the Launceston General Hospital. There an autopsy was carried out. The autopsy revealed burn marks on his lips and around his nostrils, as well as black spots on his tongue. In addition, carbon deposits were found both within his larynx and trachea.

I am satisfied to the requisite legal standard that the cause of Mr Scott's death was oxygen deprivation and carbon dioxide toxicity. This occurred as a result of Mr Scott smoking whilst using the oxygen concentrator. The rubber tubes in his nose ignited and burnt quickly as a result of exposure to pure oxygen. This in turn caused Mr Scott to inhale carbon dioxide, created by the burning rubber and at the same time not inhale the oxygen he needed.

I am further satisfied that Mr Scott's death was not suspicious, involved no other person and was an accident, albeit an accident easily avoided had basic safety warnings been heeded by him.

**Comments and Recommendations**

Section 28(2) of the *Coroners Act* 1995 provides that a 'coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate'. The circumstances of Mr Scott's death are such that I consider it appropriate to **recommend** that medical oxygen concentrators are only used strictly in accordance with manufacturer's instructions and specifically never whilst smoking or exposed to an open flame.

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

**Dated** 3 April 2018 at Hobart in Tasmania.

**Simon Cooper**

**Coroner**