MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Audrey Anne Morris

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

a) The identity of the deceased is Audrey Anne Morris;
b) Ms Morris died as a result of an accidental house fire;
c) The cause of Ms Morris' death was smoke inhalation; and
d) Ms Morris died on 7 June 2017 at 149 Youngmans Road, Dulverton, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Morris' death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; the results of toxicological analysis of samples taken at autopsy; the contents of a fire investigation report; relevant police and witness affidavits; and forensic and photographic evidence.

Ms Morris was born on 6 July 1929 in England. She grew up in Hendon near London. After training as a nurse Ms Morris joined the Royal Air Force and saw service in both Egypt in the 1950s and during the Korean War. She never married or had any children.

Ms Morris immigrated to Australia in the early 1960s. In the early 1970s she moved into the home of her sister and brother-in-law, Brenda and Robert Mitchell, and their children Catherine and Robert, at 149 Youngmans Road, Dulverton. In time the children both moved out and Ms Morris' sister and brother-in-law died. Ms Morris remained living at that address.

Very independent, but receiving much care and assistance from her niece, Catherine, and Catherine's children, Ms Morris continued to live alone despite requests from her niece that she move in with her. Reportedly, Ms Morris' health was, given her age, very good.

During the evening of Tuesday 6 June 2017, Ms Morris was home alone. Catherine arrived at the house with her son Ayden at about 7.40pm to bring an evening meal. They found the house on fire with flames coming from the area of the lounge. Catherine thought she could hear her aunt calling out. She and Ayden attempted to gain access via the only door but were driven back by the intensity of the heat. The ceiling in the laundry area fell down which also prevented access. Emergency services were contacted at 8.06pm. Catherine attempt to fight the fire with a garden hose without any success. Another of Catherine's children, Michael Mitchell (who lived close by), arrived a short time later. He attempted to enter the rear of the dwelling through a window but was unable to do so due to the dense smoke.

A crew from the Railton Volunteer Fire Brigade in a heavy tanker was the first to arrive at 8.18pm. Upon their arrival the house was seen to be fully engulfed in flames. Three other appliances with crews from Latrobe Volunteer Fire Brigade, a second from Railton and one from Devonport arrived within the next five minutes. So fierce was the fire that 12 firefighters in breathing apparatus commenced an external attack. After a short time, when the fire had been brought under a measure of control, firefighters in breathing apparatus entered the structure to search for Ms Morris. They found her badly burnt body on the floor of the kitchen.

Police Officers and Fire Service personnel remained at the scene all night until a full investigation could be carried out the following morning.

The investigation commenced early the next morning when detectives from the Criminal Investigation Branch of Tasmania Police and Fire Investigators from the Tasmania Fire Service arrived at the property. The investigation did not reveal anything to suggest there were any suspicious circumstances surrounding the fire. Specifically, there was no evidence of use of an accelerant or anything to suggest that the fire had been deliberately lit. Although the fire investigators identified evidence of electrical arcing in the fuse box, the location of the fuse box and its distance from the primary fire activity suggest strongly, and I am satisfied, that the electrical arcing at the fuse box did not cause the fire to start.

No other evidence of electrical wiring defects were determined as being possible causes of the fire. Similarly, no electrical items were identified as a possible source of the fire.

Fire investigators located the remains of the wood heater in the home. Notably, it was close to the lowest level of damage from combustion which strongly indicates that the source of the ignition was in the vicinity of the wood heater. The wood heater door was found to be closed and the heater baffle (or flue vent control) was in the 'full open' position. A wood trolley was located near to the front of the wood heater and the remains of logs were found to be present.

The most overhead damage from combustion was found in the lounge room near the wood heater. The lowest point of most fire damage was near the hearth and flooring located at the right front hand side of the wood heater. Fire investigators found that there had been more complete fire damage and activity to one lounge room wall compared to the rest of the house. All of the physical evidence points to the fire having started in close proximity to the wood heater. The cause of the fire may possibly have been as a result of a hot spark or coal being ejected (but unnoticed) from the wood heater, but it is in the circumstances impossible to reach a concluded view about that.

I am, however, quite satisfied that there is nothing to suggest that the cause of the fire was in any way deliberate.

Ms Morris' body was too badly burnt to enable visual identification to occur. Her remains were removed from the scene and transported by mortuary ambulance to the Royal Hobart Hospital. At the mortuary an autopsy was carried out and samples taken to enable toxicological analysis and to facilitate identification of her remains by DNA comparison.

Dr Christopher Hamilton Lawrence, the State Forensic Pathologist, conducted the autopsy. The autopsy revealed clear evidence of smoke inhalation and pink colouration of her internal organs. There was no evidence of any traumatic injury. Dr Lawrence expressed the opinion, which I accept, that the cause of Ms Morris' death was smoke inhalation. Toxicological analysis at the laboratory of Forensic Science Service Tasmania of samples taken at autopsy revealed that Ms Morris' carboxyhaemoglobin level was 68%, well within the reported fatal range.

Testing of other samples at Forensic Science Service Tasmania enabled conclusive evidence to be obtained to positively identify the remains located in the premises as those of Audrey Anne Morris.

Comments and Recommendations

The circumstances of Ms Morris' death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Ms Morris.

Dated 13 June 2018 at Hobart in Tasmania.

Simon Cooper
Coroner