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 Daniel James Tommerup

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

a) The identity of the deceased is Daniel James Tommerup;

b) Mr Tommerup died in the circumstances set out further in this finding:

c) The cause of Mr Tommerup's death was multi-organ failure due to, or as a consequence of, acute kidney injury and haemodynamic shock due to, or as a consequence of, thermal burns; and

d) Mr Tommerup died, aged 51 years, on 14 October 2021, at the Royal Hobart Hospital, Hobart, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Mr Tommerup's death.

The evidence includes:

- Police Report of Death for the Coroner;
- Tasmanian Health Service – Death Report to Coroner;
- Affidavits establishing identity and life extinct;
- Report – Dr Andrew Reid, Forensic Pathologist;
- Report – Forensic Science Service Tasmania – blood testing;
- Medical Records – Tasmanian Health Service – Launceston General and Royal Hobart Hospitals;
- Records – Ambulance Tasmania;
- Affidavit – Ms Jennifer Tommerup, sworn 4 March 2022;
- Affidavit – Ms Janice Dorey sworn 29 January 2022;
- Affidavit – Mr Casimir Douglas, sworn 29 January 2022;
- Affidavit – Ms Brittany Moy, sworn 18 January 2022;

- Affidavit – Constable William Mazengarb, sworn 2 June 2022;
- Affidavit – Constable Dominic Watson, sworn 15 October 2021;
- Affidavit – Detective Senior Constable Glenn Hindle, sworn 18 October 2021;
- Affidavit – Detective First Class Constable Giuliano Ercole, sworn 14 February 2022 (and photographs);
- Forensic Science Service Tasmania – Laboratory Report – accelerant testing;
- Tasmanian Fire Service records; and
- Police Body worn Camera Footage.

Circumstances of death

On Tuesday, 12 October 2021 at about 8.00 PM, police and emergency services attended reports of a man (who subsequently proved to be Mr Tommerup) on fire in the grounds of the Church adjacent to Princess Square Park, Frederick Street Launceston.

Mr Tommerup was homeless and living rough.

Passers-by had poured water onto him and extinguished the fire with blankets before the arrival of emergency services personnel.

Mr Tommerup was conscious and lucid and explained to police that he had accidentally set fire to himself.

He was taken initially by ambulance to the Launceston General Hospital before transfer to the Royal Hobart Hospital. His condition deteriorated markedly and two days later, on 14 October 2021, Mr Tommerup died.

Investigation

Mr Tommerup's body was formally identified and then transferred to the hospital mortuary. At the mortuary, experienced forensic pathologist Dr Andrew Reid performed an autopsy. He found extensive evidence of thermal burns to over 60% of Mr Tommerup's body. Dr Reid expressed the opinion that the cause of Mr Tommerup's death was multi-organ failure due to acute kidney injury and haemodynamic shock as a result of those thermal burns. I accept Dr Reid's opinion.

Blood taken at the time of his admission to hospital was subsequently analysed at the Forensic Science Service Tasmania laboratory as part of the investigation. A significantly elevated blood alcohol concentration was detected as having been present at the time of Mr Tommerup sustained his burns.

The circumstances in which Mr Tommerup sustained those terrible burns were comprehensively investigated by both police, Forensic Science Service Tasmania (who carried out additional analysis of clothing samples and were able to positively rule out the use of any accelerant) and the Tasmania Fire Service.

All of the evidence obtained has informed this finding and my conclusion.

Conclusion

There is no evidence to suggest that Mr Tommerup's burns were due to anything other than an accident – as he told the police at the time.

There is no evidence that his death was suspicious or that any other person was involved in it.

I observe that despite a protocol for referral and urgent transfer of burns patients with greater than 50% burns to specialist burn services in Hobart or Melbourne, Mr Tommerup's transfer did not occur straightaway. I note that his medical records indicate that his case was discussed in a timely manner and agreement reached for transfer to Hobart or Melbourne (with the Royal Alfred Hospital having agreed, in principle, to receive him) but the transfer was hampered by pandemic restrictions.

To my mind the delay was not particularly great, understandable in the context in which it occurred and unlikely to have had any impact on the ultimate outcome for Mr Tommerup.

Comments and Recommendations

The circumstances of Daniel James Tommerup'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 convey my sincere condolences to the family and loved ones of Mr Tommerup.

Dated: 19 September 2022 at Hobart in the State of Tasmania.

Simon Cooper
Coroner